

# PUBLIC HEALTH



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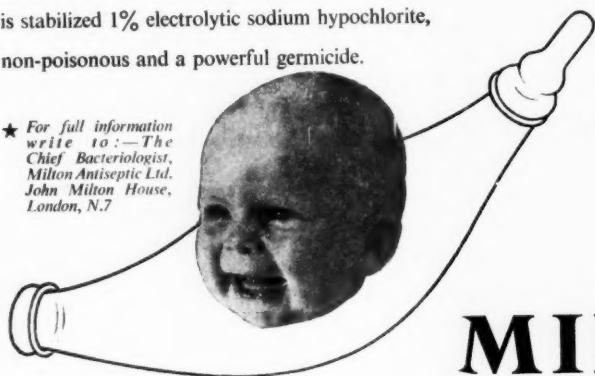
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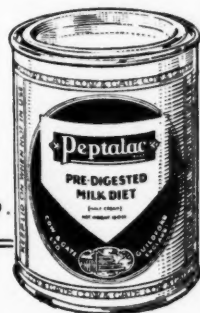
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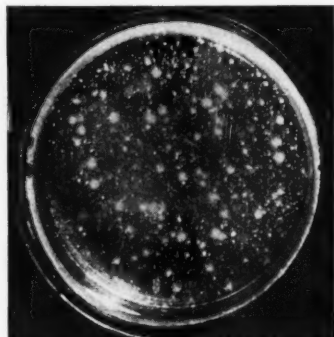


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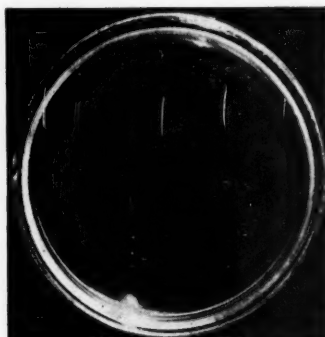
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## EDITORIAL

### Thoughts from a Full Career

Our ubiquitous and esteemed Chairman of Council, Sir Allen Daley, was last year elected to the presidential chair of the Section of Epidemiology and State Medicine of the Royal Society of Medicine. His presidential address, delivered on May 2nd last, has now been published in the September, 1949, *Proceedings*\* of the R.S.M., under the title "I Remember." Few members of the public health service have had such varied urban experience as Sir Allen, although he himself confesses that he has not done public health work in a rural county. He was first for nine years M.O.H. of Bootle, then for five years of Blackburn, then for five of Hull, all leading up to his 20 years at County Hall, London, first as deputy to the late Sir Frederick Menzies, and for the last ten years as County Medical Officer of Health. His colleagues will be glad that Sir Allen, rather than composing a presidential address on some particular subject, has instead turned to the fruits of his long experience and the records he has kept in his various appointments, and as a result produced a fascinating medley of reminiscences which, incidentally, contains a wealth of wisdom on various topics. For instance, he wrote a paper on "Home Helps" in 1920, and records that, in the first instance, he chose those ladies on the basis of smartness and good looks. The experience gained from that showed that women did not want other smart, good-looking women in their houses but preferred them plain if their husbands were likely to be about the house as well. We gathered that although good looks were at first grounds for disqualification, once the scheme had got going they could again be chosen irrespective of their appearance.

Under "Health Education," Sir Allen records his discussions with philosophers, the clergy and others, whether the young adult is more influenced in propaganda against VD by lurid pictures of the personal risks he is running or by an appeal to avoid exposure because of possible effects on his future wife and children, and the unanimous view that the latter is the more fruitful approach. He has some interesting recollections of controlling smallpox, including a reference to the first appearance in this country of variola minor. Later he turns to the scrutiny of public health costs which resulted from the 1921 Geddes Axe, when he discovered that in county boroughs the expenditure of health departments varied from 2s. 3d. to 9s. 4d. per head of the population and from 3½d. to 2s. 6d. in the £ of rateable value. At that time, of every £100 spent by the health departments, £26 was on work against infectious diseases, £30 on anti-tuberculosis work (in both cases the most part being on hospital or sanatorium maintenance); £13 on M. & C.W.; £9 on school health;

£5 on V.D.; £2 on food and milk control; and £15 on general sanitary work and administration. He records his conclusions on the distribution of the total monies at that time and suggests that, as financial stringency is again beginning to appear, the time may have arrived for another similar review. His passages on administrative work and research reflect his intensely exacting period in the planning of the L.C.C. hospital service, which he said gave him as a medical administrator the greatest satisfaction of knowing that he could still serve the sick, although he had a deep-rooted adherence to the importance of preventive medicine. Under "Medical Education," he reminds us of the foundation of the British Postgraduate Medical School at Hammersmith, and under "Local Government" he again records his disagreement with those who suggest that medical officers of health should become State officers. "Their work," he says, "in the environmental health services and the school health services is too inextricably mixed with duties which must remain in the field of local government for any separation to be possible without lessening materially the efficiency of the service." Speaking of unified administration, he wisely points out that "when administrations are separate and independent, everyone is sensitive about his dignity and develops a loyalty to his own administration, coupled, it would appear, particularly in the lower ranks, with a distaste for, and suspicion of, other administrative bodies and their officers." How true this thought is when one considers the difficulties experienced during the last 18 months in establishing contacts even at officer level between the various forms of administration under the National Health Service.

In his final reference to his experience of the war years, he again pays tribute to local government when he says "I have been more and more impressed by the zeal and devotion to the cause of their fellow citizens which animates those who serve the public, quite voluntarily, as members of local authorities. They receive little thanks and much abuse. The public health services of this country could never have shown such astounding success as is evident in recent vital statistics if they had not listened to the advice of their medical officers of health and found the necessary cash to implement that advice." Nor, we may add, if they had not attracted to the Local Government Medical Service men of the calibre of Sir Allen Daley.

### A Health History of Southampton

Dr. H. C. Maurice Williams, O.B.E., this year's President of the Society, includes in his Annual Report for 1948 the first part\* of a historical survey of public health in Southampton,

\* Available as a reprint, "Public Health in Southampton, 1850-1900."

covering the years 1850-1900. He proposes to deal with the second 50 years in his next report.

The advertisement for the appointment of Southampton's first health officer, in 1850, specified his duties as follows:—

"The gentleman appointed is expected to report periodically on the sanitary conditions of the town generally, to ascertain whether any contagious epidemic affecting the public health exists, and to take charge of the common lodging-houses."

Dr. Francis Cooper was appointed at a salary of £75 per annum, with permission to continue in private practice. When he died of Asiatic cholera in 1865, the advertisement for his successor appears not to have stipulated medical qualifications in the candidates, for they included a plumber, one applicant of independent means, one "strongly supported by his father, Mr. Spooner," and three doctors. However, the choice fell on Dr. McCormack, at a salary of £150, without permission to engage in private practice. He moved on, in 1871, to become M.O.H., Lambeth, no doubt stimulated by the glaring contrast of his salary with that of the then Town Clerk, who received £400 as Clerk to the Council and £400 as Clerk to the Local Board of Health.

Dr. Henry Osborn, M.R.C.P., the next in the line, was appointed in 1874 at a salary of £250 per annum, of which the exchequer repaid half on condition that he did not engage in private practice, and there was a separate part-time port sanitary officer (Dr. Harry Bancroft), on whose death, in 1884, the two posts were merged. Dr. Wellesley Harris succeeded Dr. Osborn in 1890, and was still in office in 1900.

From the epidemiological aspect the big event of the period covered, apart from steady environmental improvements, was the cholera outbreak of 1866, well described by Dr. Williams, which caused 100 deaths.

Such historical surveys compiled from the records of the time have a more than local interest. We hope that other medical officers of health may find time to extract the local history of the public health service which, in so many towns, now extends over at least 75 years.

### The Epidemiology of Coronary Disease

Prof. John Ryle, of the Oxford Institute of Social Medicine, has given a valuable impetus to the study of the degenerative diseases by his analysis of the epidemiology of coronary disease. Readers will recall that his book, "Changing Disciplines," contained a reference to this subject in illustration of his main thesis that the scope of social medicine should extend to cover the whole range of man's afflictions. A further study, undertaken in collaboration with W. T. Russell, the statistician of the Institute, has now appeared in the *British Heart Journal*.<sup>\*</sup> This combines a statistical study of the incidence of coronary disease for England and Wales (as shown in the Registrar-General's mortality figures between 1926 and 1945), with an analysis of Ryle's own clinical experience during a similar period of 23 years in consulting practice. The official figures reveal an increase in standardised mortality amounting to 12 or 13 times. In a critical analysis of this occurrence, the study first suggests that even when allowance is made for an ageing population, a definite and steeply rising incidence is still present. This is followed by evidence that this rise cannot be wholly due to "a transference of deaths from other forms of circulatory disease"; in particular, the possibility of transference having taken place from a myocardial group is examined. A third important analysis reveals that the increase has been fairly uniform throughout life and that a transference of deaths from "old age" does not offer an adequate explanation of the increased mortality from coronary disease.

Thus, we arrive at a measure of certainty that coronary disease has been rapidly increasing, and the question is—why? When we examine this question of why, the first important point to note is that the incidence in men is much higher than in women (at age 40 to 50 five times greater) and in a way which is demonstrably absent in myocardial disease. The second point is that there is a correlation with social class which must be read in conjunction with the difference between

the sexes. Social Classes 1 and 2 are very much in excess of the average, Class 1 males being 137% in excess and Class 2 males 46%. Wives join in this excess in the two upper groups but with a much lower incidence. Within the same social groups the sex ratios of men and wives showed an excess for the men at the age group 45 to 55 amounting to ten times for Class 1, five times in Class 3 and three in Class 5; in contrast no such gradient was found for myocardial disease. Whatever the cause may be, it operates especially in the first two social classes, affecting men more than wives, and most potently in the 45 to 55 age group when men exceed wives by ten times. As to geographical incidence, the report can say little because of our ignorance of the differences in social structure in different areas, but for what it is worth there is an excess of 21% above the average in Greater London, 11% excess in the residual south-eastern counties and 3% in North I; with North IV, Midlands I and II, and South Wales with 15% below the average, and North Wales with deficit of 3%.

Ryle's own cases totalled 243 (164 males and 79 females). In age of onset there was a greater male preponderance in early and middle life. Where it was possible to indicate the occupation clearly, the main professions for 100 men included 39 men engaged in business, 19 physicians and surgeons, six clergy, six officers of the armed forces, six justices, judges or solicitors, and four engineers. Among 47 women, eleven were single, of whom five were gainfully occupied, and there were 36 housewives, four being also gainfully occupied. Ryle's entries about associated illnesses yielded a suggestion of the association of cholecystitis and gallstones; 9% of the males gave such a history. Other conditions, e.g., migraine, duodenal ulceration, obesity and diabetes, were not recorded sufficiently often to suggest anything more than a chance relationship. About half had a raised blood-pressure, either systolic and diastolic or systolic alone, but a history of associated vascular lesions occurred in only 4% males and 7% females, and the reader is left with the impression that Ryle has considered the possibility that coronary disease may be due in part to some local selective effect.

What is the precise aetiology? Obviously, Ryle does not pretend to give the answer in full. He makes it plain, however, that he regards both his own experience and the evidence provided by Russell's figures as pointing clearly to nervous strain as an important influence. In social Class 1, and particularly at age 45 to 55, the workers included "have usually reached the peak of their professional careers and are exposed to the maximal strain associated with their particular responsibilities." Physicians and surgeons head the standardised mortality list (368), proprietors of wholesale businesses come a bad second (235), judges, barristers and solicitors third (227), and clergymen of the Anglican Church fourth (218). These four occupations with the greatest liability to death from coronary disease are those "requiring not only a high degree of mental activity, but also involve considerable anxiety and stress in their performance." The weight of evidence is such that there is no longer any reasonable doubt that the changes in the coronary vessels take place as a result of physiological and intrinsic biochemical processes which are set in operation predominantly by nervous action. Heredity predisposition also plays its part, but the "multiple factor," in which age, sex, occupation, genetics and mental stress are all contributory, is, at present, the most rational.

More than this, and this in itself is a lot, cannot at present be stipulated. Smoking and alcohol could not be certainly incriminated. There is the possibility to which Cassidy called attention in his Harveian Oration (1946) that the remarkable sex incidence is due to chemical processes having their origin in maleness, but this is offset by the indications contained in Russell's analyses and Ryle's cases that women do themselves suffer when the processes of mental stress are sufficiently in evidence. The possibility that cholesterol metabolism may be involved at some point in the chain cannot be wholly excluded. Infection and nutrition are ruled out by the authors, perhaps a little summarily. Readers will remember that Geiringer's study of blood vessel walls in relation to age, published in the *British Journal of Social Medicine* (1948),

\* Oct. 1949, 11, 4370

pointed to nutritional rather than pressure effects in the atheromatous changes of the ageing aorta. The change must have some nutritional basis, using the word in the widest sense, but Ryle, presumably, means that there does not appear to be any reason to suspect any gross difference in dietary habit between sufferers and non-sufferers, and suggests that any chemical pressor substances involved are endogenous.

This fine lead in unravelling one of the most important of the present day problems of community health must be followed up by further intensive research, both with a view to determining more precisely what are the initiating processes, and also what are the intermediate chemical steps in the chain of causation. Either of these lines of approach, particularly the second, might lead to a discovery which could place in our hands a means of defence, but human habits and work and the stresses they involve are also ultimately modifiable and cannot be neglected.

### The Products of Fission

How stands tuberculosis to-day? A glance at the epidemiological returns in Europe shows the mortality rate for respiratory tuberculosis to be falling. In fact, almost every European country reveals some improvement apart from Spain, Portugal, Eire, Scotland, England and Wales. In the United States a striking decline has been noted in recent years, and in an industrial region like New York State the mortality-rate (including coloured races) had fallen, by 1947, as low as 30 per 100,000. In this island the picture is gloomy and sombre. During the past three years, the corresponding mortality-rate for Scotland has risen from 62.7 to 65.8, and even in England and Wales the death-rate has risen from 35.9 to 36.4 per 100,000. We feel we are therefore justified in concluding that, in this country, we are failing to halt the advance of this disease. Moreover, it was just at this critical phase in the battle that the National Health Service Act was introduced. The clinical functions of the old tuberculosis service have been assumed by the new Regional Hospital Boards, and prevention continues to be the rôle of the local authorities. This dissection of the National Tuberculosis Service is full of the dangers and disadvantages of divided authority and responsibility. Still, the decision was taken and it is therefore most timely to read Prof. Frederick Heaf's recent Presidential Address to the British Tuberculosis Association\* on this very subject.

While expressing his regrets at the disintegration of the old tuberculosis service, Prof. Heaf draws the attention of his audience to certain opportunities the new organisation presents. Under Section 28, the local authority is now charged with the duty of establishing a service to prevent tuberculosis and is empowered to provide a rehabilitation organisation. Moreover, there is a wide field for fruitful liaison between local authorities and Regional Hospital Boards. Common ground for co-operation exists in the exchange of statistical information, the use of mass radiography units in selected young industrial groups or employees practising dangerous or dusty trades and occupations, the management of the "open" chronic case of phthisis in hostels and in the provision of a rehabilitation organisation. Joint committees are not merely essential to avoid needless overlapping and friction, but to ensure that all important duties are undertaken and not ignored in the pious hope that they will be completed by the other party. There is, however, a further and equally serious danger ahead, in any attempt to remunerate chest physicians on two distinct and unequal scales—an upper scale for clinical work on the accepted Spens level and a lower scale for preventive and after-care work on a scale yet to be determined. As Prof. Heaf very sagely remarks in his address, "Any suggestion of a lower rate of remuneration for preventive and after-care work" . . . "must be rigorously opposed, as there can be no argument that preventive work requires less skill or is of less importance than the administration and application of treatment." The mute acceptance of Ministerial policy on this question can lead to a most pernicious attitude of mind in the medical officer of health or chest physician, who may come to regard this part of social medicine as being of little significance.

\* *Tubercle* (January, 1950).

The Ministry has taken this step in differential remuneration in a belated and faltering fashion, and it seems to us that an extremely important principle of equality in clinical and preventive work is at stake.

Finally, if some progress is to be made in the battle against tuberculosis, an imaginative and co-operative approach by the Ministry, Regional Hospital Boards and local authorities is essential.

### Recent Research in Nutrition

The three numbers of Vol. II (1948) of the *British Journal of Nutrition* are well up to the high standard achieved by the first volume of the previous year. McCance and Walsham give an entertaining account of another human experiment of the type which we are now getting used to from the Department of Experimental Medicine in Cambridge. They studied the digestibility and absorption of Canadian and English wholewheat. Three men and three women lived almost entirely upon bread for periods of eleven days. One of many interesting observations on the state of their metabolism was the negative calcium balance due, it appears, to phytic acid fixation of calcium in the gut, and one subject developed tetany on the tenth day of his second period. In a similar experiment with oatmeal providing 93% to 100% of the calories in the diets of six men, all were shown to be in negative calcium balance and one had a severe attack of tetany at the close; if any doubts remained of the importance of phytic acid in wholewheat and oatmeal, these experiments should dispel them. Chick and Slack publish their observations from the Lister Institute on the nutritive value of the proteins in wheat flours of different extraction rates. They conclude that nutritive efficiency for the support of growth in young rats is about 20% greater from the protein of wholewheat than those of white flour of 70% extraction; at 85% extraction the value was undiminished, but at 80% the value had fallen almost as low as that for 70% extraction. This supports the view that we should maintain an 85% extraction rate. Hinton (Cereals Research Station, St. Albans) adds further weight to the need for such a precaution with rice by showing the high concentration of aneurin in the scutellum and aleurone layers. The occurrence of rickets in pigs fattened upon diets containing large amounts of yeast, which had been previously demonstrated in the University of Reading National Institute for Research in Dairying, has been further studied without discovering the cause; the possibility that it is due to something in the yeast which inhibited the breakdown of phytic acid has, however, been disproved; whatever the causal factor, it is heat stable and present in autoclaved yeast. Medical officers of health and school medical officers will be particularly interested in the symposium on school meals from the 44th Scientific Meeting of the Nutrition Society held at Edinburgh. It is evident that in 1943 the average meal supplied fell much below the Government's recommendation of 1,000 calories, 30 gm. of fat, and 20 to 25 gm. of protein; the general average in one sample of 56 meals was little more than half these figures; ascorbic acid was particularly low. This is not surprising and accords with other observations. It was, however, an encouraging finding that a similar analysis in the same schools the following year showed considerable improvement, and most would agree that "improvement was general and could be attributed in part to normal development of what was, on such a large scale, a comparatively new service." More analyses of this sort would be a valuable addition to school health annual reports everywhere. There is an account of a study of famine oedema in 27 subjects in Holland and Germany at the end of World War II, which suggests that the condition exists in two forms, one with and one without hypoproteinaemia.

There are two useful accounts of different methods of making individual dietary surveys from the Department of the Government Chemist (Bransby, E. R., Daubney, and King, J.). In the second (a comparison of diets chemically analysed and estimated from tables), "the differences between the values found by calculation and by chemical analysis were in many instances so large as to throw doubt on the usefulness of the individual results obtained by calculation." A sym-



posium from the 45th Scientific Meeting of the Nutrition Society on the Results of Recent Investigations of Nutritional Status in Great Britain, is worthy of study. It is a little disappointing to find how little real evidence exists of what is the exact nutrition state in Great Britain, and the reader who has digested the erudite contributions of Marrack, Yudkin and Sinclair will not find himself much advanced. Much of this difficulty, however, exists because Great Britain has no frank deficiency diseases and in that vague borderland of medicine between the absence of disease and positive health nutritionists are likely long to wander without finding their bearings. A study of fats as food was made at the 46th meeting held at Glasgow. A finding of interest is that butter fat is not superior to vegetable fat in growth promotion. Finally, there is a discussion in the 48th Scientific Meeting of the Nutrition Society at London on the Nutrition of Athletes. This is entertaining if, as one might expect, not very conclusive.

### THE SERVICES HYGIENE GROUP\*

By H. D. CHALKE, O.B.E., T.D., M.R.C.S., L.R.C.P., D.P.H.  
Lieut.-Colonel R.A.M.C. (T.A.),

*Divisional Medical Officer, London County Council*

The subject of this address allows of much digression and excursion into many fields of public health and Service hygiene. Indeed, it was chosen with that object in view. How extensive are the interests of this group is perhaps not fully realised, and my aim is to draw attention to its functions, and to put forward suggestions as to how best it may fulfil them.

At the outset I should like to say with what pleasure I have noted the change of name of the Hygiene branch of the Army. It is now the Directorate of Army Health. It is fitting that our immediate Past-President, Brigadier A. E. Richmond, who has had so much to do with this metamorphosis, should be the first Director of Army Health. Some may ask, "Why is a change of title necessary?" There is a lot in a name. Man—civilian and soldier alike—has forgotten that Hygieia's destiny is to watch over the health of mankind, but the science that bears her name has come to have a garbled meaning. The new title may help to remove the widely prevalent conception that "hygiene" is almost entirely connected with latrines, sullage, and the Horrocks' box, with the destruction of things that creep, crawl and fly—and with little else. This etymological blunder is, alas! not confined to junior officers and men. "Sanitary" has become even more debased. To most people it is synonymous with plumbing and ordure. In both civilian and army circles, there should be a new designation more fitting to the work of the inspectors and units engaged in safeguarding health.

It is gratifying to note also the great stress now being laid in the army on "positive health," as opposed to the negative concept of "no disease." The mandate of the Army Health Service is "The attainment, maintenance and enhancement of physical and mental health and the prevention of disease." Hygieia would have approved of these aims.

#### Comparisons between Civilian and Army Health Services

In the past the wartime soldier has been exposed to greater health risks than the civilian, but total warfare has tended to alter the position. In peacetime, the hazards of health in the Forces, both at home and abroad, are rapidly being diminished. I believe the added risks attendant on the close association of men in the army to be somewhat exaggerated nowadays. The medical services of the army offer great possibilities for the organisation of an almost perfect health service, a service in which positive health and disease prevention receive more prominence than curative medicine.

The general practitioner, and his opposite number the unit medical officer, are the pillars of an efficient health service. The general practitioner of to-day has little time to devote to preventive medicine. How different were his father and

grandfather, the family doctors of the past! He has scant opportunity of knowing his family as a Unit. The regimental medical officer, on the other hand, comes to know his unit as a family, at work and at play. The manner of their feeding, housing, and clothing is understood by him, and he can judge the health risks which may confront them. The morale and sickness-rate of his troops are a reflection of the influence he exerts on the C.O., and, of course, on the way the C.O. reacts to this guidance. The knowledge that, as far as possible, his men are placed in the jobs for which they are physically and mentally best fitted gives him an advantage denied to his black-coated colleague. The young doctor serving his term of military service is fortunate to learn something about the influence of environment on health so early in his career. He sees the healthy as well as the sick; he never did this as a medical student or house-man. These doctors will bring this knowledge with them into civilian practice, as those who served in the war have already done.

The child in this country is well looked after in respect of "positive health." For the majority, the watchful eye is removed at school-leaving age. The Industrial Health Service does, indeed, provide a continuity, but at present it caters for a very small section of the community. In the lesser concerns the main stress is often on treatment and first-aid. In those industries wherein an efficient medical service has been established, it has been found that it pays a handsome dividend in decreased invalidism, a better employer-worker relationship and thus increased output. The army hygienist has many duties in connection with "occupational" health. He, also, was not unaccustomed to meeting difficulties and frustrations in his campaign for better health. It was the stark reality of dangerously high non-battle casualty rates that gradually brought about improved co-operation as the war proceeded. This concurrent effort was well repaid and was followed by increased efficiency and saved man-power. The victory in Burma, largely a "hygiene" victory, is perhaps warfare's most outstanding example of how appalling disease perils can be circumvented when there is full support from a far-sighted commander. But memory is short lived, and to those "dazzled with the noise of Victory," the contribution made by the hygiene services tends to be obscured.

During the war, those engaged in hygiene work formed a very small part of the medical services. It is hoped, confidently, that in the New Army their number will be very much increased. But this is not enough. The pivotal position in affairs of health occupied by medical officers in charge of troops must be kept prominently in mind, and greater stress laid on this aspect of their initial training. Is it too much to hope that many of these officers will be enabled to achieve the senior ranks at present denied to all but specialists or administrators? I put forward the suggestion that selected army health officers should be seconded for short periods of service in civilian public health departments from time to time.

The contributions to preventive medicine made by the Services are too well known to need mention here. Apart from the more spectacular work, as in the control of communicable diseases, there have been other advances of a less conspicuous, but no less important, character. I believe that the medical inspection of recruits was one of the origins of our personal health services. The P.U.L.H.E.E.M.S. system of medical classification and Personnel Selection have followed. Physical efficiency tests, development centres, conditioning courses, and rehabilitation schemes have been established. All these have an important place in a health scheme, and we should not be slow to take advantage of the experiences of our Service colleagues. An exchange of ideas on matters of this sort is one of the functions of this group.

#### Health Education

Never before in the history of this country has health education been disseminated to so many as was the case during the war. Tens of thousands of civilians in uniform passed through the Army School of Hygiene. Almost continuous courses of instruction were given by Hygiene Sections at home and abroad. There was unceasing individual propaganda by hygiene officers and N.C.O.s. This work has not been entirely

\* A synopsis of the Presidential Address to the Services Hygiene Group, Society of M.O.H., London, October 21st, 1949.

wasted, and one still sees evidence in civilian life that all of the seed did not fall on barren ground.

In 1922, a special committee of this group prepared an exhaustive report on Health Propaganda. I will quote the opening sentence. "A complete scheme of co-operation between the armed forces and civil population in matters of hygiene and public health, must embrace an interchange of views and experiences and educational propaganda work." There follows a detailed description of the sort of propaganda that should be used, and the report concludes by suggesting a central organisation to act as a liaison between existing agencies, civil and service. This document must be read to be appreciated. The suggestions made then are recognisable as the guiding principles of health education as we know it to-day. The impetus of war threw a new light on health teaching and propaganda in the army, and this aspect of the work of the Army Medical Service has reached a high standard. This group may consider that there is a need for further consideration of this subject. We know that By-laws, King's Regulations, and Routine Orders do not themselves produce better health, and—

"We smile at the unwisdom that could expect to regulate private lives by statute."

How true it is that in a force (or a community) where education has brought into being habits that engender good health, few orders and statutes concerning it are needed. Their multiplicity is an index of the lack of these habits.

#### The Army Health Service and Civilian Health Problems

Whatever differences of opinion there are about other aspects of conscription in peacetime, few will deny its importance with regard to health training and education:

"Thou durst not thus disparage glorious arms!"

There is now a periodic ebb and flow of young people to and from civilian life. This has not happened before. These men have been properly examined and their employment capabilities assessed. They are given excellent opportunities of improving their physical and mental make-up, and of forming good health habits. A reasonable amount of their training time is, we hope, being allotted, also, to specific instruction by the Army Health branch. The hygiene officers and men of the Territorial Army are already doing a lot of educational work in non-medical as well as medical units. They are thirsting for more. When the National Servicemen arrive, their army schooling will be continued. These involuntary members of the T.A. will reap the benefit of the practice we are now getting on the voluntary ones.

When the soldier leaves the Forces his health record and his job assessment should be available to the industrial medical officer, or any other doctor concerned. If this is not done, invaluable information is lost. A large industrial concern has brought into use a modification of the P.U.L.H.E.E.M.S. system which, I understand, has proved a great success. It is a step in the right direction, for which its originator—who had a distinguished military record—is to be congratulated.

There is a clear case for the adoption in this country of a standard system of medical classification based on the army method, which with minor modifications would be adaptable to schools, factories, civil defence, insurance, etc., as well as the armed forces.

Perhaps the time is not far distant when employers will require this form of medical report in respect of all who present themselves for employment. These are points we should discuss at a joint meeting with the Association of Industrial Medical Officers.

#### The Army Health Service in War

You who served as hygiene officers during the war will need no reminding of the close relationship between civilian health circumstances and the health of the troops. This applied at home as well as overseas. *P. capitis* infestation and scabies, diphtheria, food poisoning, V.D., and industrial diseases amongst others, as well as difficulties of accommodation, water supplies and sewage disposal were important problems on the home front. Looking back on those troubled days,

I cannot but deplore the fact that this group no longer existed. It would have prevented the occurrence of many inconveniences and perplexities. The regular hygiene officer would have been in closer touch with the M.O.H. and his work, than was the case in 1939, and many M.O.H.s would have better appreciated some of the factors peculiar to army hygiene. In the rush of war there was no time to consider the proper siting of permanent and temporary camps. The absence of a pre-arranged scheme was "worse than a crime, it was a blunder." Shortly before the first world war a committee of this group commenced "County Surveys." The object was to obtain a complete picture of the public health circumstances in the counties, for the benefit of the army in an emergency. This work was carried out in only two counties. It is a matter to which this group should again give thought. It will have a place in the integration of the work of the Civil Defence Corps, and the Army medical services, with which we may be concerned.

It was overseas, however, that civilian health became such an important factor. In modern warfare there is enormous destruction of towns, a disruption of municipal services and disorganisation, or cessation, of medical arrangements. In any future warfare the full resources of the army health branch may be needed to contend with these problems. The Allied Military Government and the Allied Commission were formed during the Italian campaign. They were, in theory, responsible for civilian public health. But the hygiene of an occupied country cannot be placed in two separate compartments. Hygiene sections have to accept full responsibility for this work in the forward areas, and to a large extent elsewhere. The resources of A.M.G. and A.C., were very limited, and they had to beg equipment, stores and transport, from the Allied Armies. Even with the closest possible co-operation, such as existed in Italy, this plan is not workable. The soldier and the civilian cannot be under two yellow flags of slightly different shades. There should be but one hygiene service under the direction of the D.M.S. of the Force. In this way, and only in this way, is it possible to utilise the available hygiene resources to the best advantage.

#### The Work of the Hygiene (Sanitary) Sections

These units played no obscure part in the victory of our arms. Their work is all the more commendable because to most of those who served in them malaria, typhus, and the like were mere names. Their public health experience at home served them in good stead in occupied countries. The officers and staff sergeants of these units often became "acting unpaid" M.O.H.s, port medical officers, food inspectors, and borough engineers. Their greatest assets were initiative and a faculty for improvisation. They could chlorinate a town water supply at the source or manufacture in their workshops anything from "iron lungs" to office equipment and field hygiene appliances. Their productions, like the Earl of Dundonald's teapot, could be labelled "S.Y.P.: Simple yet perfect." With Emerson, they believed that the highest price one can pay for anything is to have to ask for it, although they sometimes interpreted this a little broadly!

One section issued clean food certificates to restaurants where the standard was exceptionally high; another gave courses of instruction to Italian women so that they might act as "health visitors." The results exceeded all expectations. There is time for a word about malaria and typhus, two diseases of evil portent to our troops in the Mediterranean theatre. There were 300,000 cases of typhus in Algeria in 1942. The British Force that landed in November, and was un inoculated, escaped with but a few cases. The Hygiene Sections played a vigorous part in this, as they did in Italy later. It will be recalled that in Tunis, in 1902, Ch. Nicolle, having shown that the louse was the vector, rid the country of its 2,000-year-old scourge within two years. Forty years later, North Africa was ravaged by one of the worst outbreaks in its history!

Hygiene Sections had their share of malaria control work, which did much to counteract the poor malaria discipline of the Force. In Algeria the disease is very localised; great numbers of road signs, marking "Safe" and "Dangerous"



camping areas, were prepared and erected. These, undoubtedly, prevented an untold number of malaria casualties. In two areas, the sites of military hospitals and camps, the French warned us of the malaria dangers to come. In one place, the offending swamp was drained, using Arab labour. (French and Army engineers said the project was impossible.) In the other, irrigation canals and a river were dealt with in the face of local opposition. There was no malaria in either place that summer.

Algeria is associated with the name of Albert Laveran, who discovered the malaria parasite in Constantine. The almost complete absence of field control measures, for which the war was, perhaps, to blame, was very disappointing, since we found that control was not difficult even in the pre-DDT era. How sad it was to find the dwellers in the village that bears Laveran's name suffering from a disease which should have been eliminated!

Other preventable diseases, such as smallpox, took their toll of British lives in North Africa. The sad story of "No visible evidence of recent vaccination, notwithstanding record of vaccination in pay book," was oft repeated. Those who should have known better often delayed re-vaccination of contacts until too late; one sequel of this was the occurrence of 50 further cases in a medical establishment. People who consider that specialists in infectious diseases are redundant, should read the medical history of this campaign. One wonders what Nicolle, Laveran, Jenner, and their colleagues in that Valhalla which must surely be reserved for the immortals of preventive medicine, must have thought about it all.

The treatment with DDT by the Hygiene and Malaria Control Units of the Eighth Army, of every castle, cottage and cowshed in Central Italy, is an example of preventive work unique in the annals of war medicine.

We must leave the hygiene sections with most of their story untold, remembering of those who served in them that—

"The wisest thing, we suppose, a man can do for his land is the work that lies under his nose, with the tools that lie under his hand."

One of the first tasks in an occupied country is to assist the public health and laboratory services to re-establish themselves. This gives direct as well as indirect benefit. We owed a great deal to the co-operation of most of the public health officers in Algeria and to the Director of the Pasteur Institute. In Italy, also, we were able to help with equipment, electrical supply, and in other ways (at the Slavo Institute, for example), so that the supply of vaccines and sera for civilian use could be recommenced or augmented. By doing this, we ourselves obtained typhus and smallpox vaccines and anti-rabies serum.

In the early days of the Algerian campaign, local French laboratories gave invaluable assistance in connection with venereal disease diagnosis and control. Mention must also be made of the splendid work done for the army at home by the Public Health Laboratory Service.

The chance meeting with an Italian Fellow of this Society enabled immediate and estimable contacts to be made with other hygienists and malarialogists. This prompts me to suggest again the desirability of inviting distinguished foreigners in the public health field to become Fellows of our Society.

### Conclusion

However desultory and disjointed this talk, I hope that "there is some method in the fragments." My endeavour has been twofold: to show how important has become the civilian aspect of army health and to point out the position we occupy as a connecting link between the civilian and the Forces health services.

Since its revival, in 1946, the membership of this group has increased to more than 250. What is most gratifying of all is the number of serving officers—about 60—who are now members.

It has given us a means of maintaining the contacts and friendships of the war years. The bowler hat and the service cap have come to know each other better through its agency. But the Services Group is more than that. It is a medium

for the utilisation of experiences in health matters and the exchange of up-to-date knowledge between you in the Services and us in civilian life. Each has much to learn from the other.

We find ourselves, therefore, in a position of no little responsibility, and no opportunity should be lost of putting this unique association to the best use.

The group achieved great distinction in the decade following the first world war. It made many valuable recommendations to the Council of the Society, and I have enumerated a number of its other activities. I will add one more, which is the hope expressed to the directors of the three medical services, that they would invite the group to co-operate occasionally "in some matter of research in which they might be adjudged capable of rendering assistance."

Let us follow in our elder brothers' footsteps, remembering that we have a definite mission to perform. "Don't let us lose ourselves in the crowd."

### PUBLIC HEALTH IN THE ARMY, 1939-45 \*

By W. R. MARTINE, O.B.E., T.D., M.D., D.P.H.,

Senior Assistant Medical Officer of Health, City of Birmingham

I do not intend to follow in the footsteps of my predecessors, either by painting a rosy future, or by casting doubts upon the prospects of the medical officer of health. Because anything I might forecast could be nothing but the wildest conjecture, I propose to give you, instead, some of my reflections upon the duties and inevitable shortcomings of the specialist hygiene officer temporarily in the Services, particularly the military services, between 1939 and 1945.

There existed in 1939 little more than the peace-time establishment of hygiene specialists in our army, with a few—on paper—in the supplementary reserve. There were a few more in four Territorial Army hygiene companies and tucked away in other Territorial units, some of them of senior rank, and, like some of their regular colleagues, too senior for the small number of hygiene appointments available to the Territorial Army. Subject to having passed the requisite examinations, one rose automatically to the rank of major in 12 years, whether one were a specialist or not, and subsequent promotion depended ultimately upon a fixed establishment and upon the occurrence of a vacancy in the ranks of lieutenant-colonel or colonel before one reached the age of retirement for one or other of these ranks. For these reasons, therefore, a number of assistant directors of hygiene had not reached the rank of lieutenant-colonel in 1939, and some of the more junior hygiene specialists were actually captains, all, however, being in receipt of specialist pay while so employed.

It became obvious long before 1939 that, if war came, there would be a real need for many more specialists in all branches of medicine, and discussions took place between representatives of the various services and civilian medicine. The latter took a firm stand on that occasion, insisting that any medical officer holding a specialist appointment should hold major's rank at once, in addition to receiving specialist pay—irrespective of whether he had ever had any practical experience in his speciality or not. As far as hygiene was concerned, the only necessary qualification was the D.P.H., irrespective of whether it had been used or not, and no experience of organisation and administration in the services other than a few weeks' instruction at the R.A.M.C. Depot and in the Hygiene Department of the Royal Army Medical College, was required. Membership of the Officer Cadet Reserve of the Senior O.T.C. was not even a basic qualification as indicating some slight experience of military hygiene. It is not for me to argue the right or wrong of such an arrangement, suffice it that the men had to be found, the terms had to attract and the Treasury was prepared to give in.

Now it is just as well to consider for a moment the work these officers were given.

\* Presidential Address to the Midland Branch of the Society, Birmingham, October 13th, 1949.

(1) They were to be engaged in inspection of camps and billets, including the sanitary accommodation and cookhouse.

(2) They were to be responsible for the planning of the work of a team of sanitary inspectors, and for supervision of that work.

(3) They were to give advice as to the sanitary provision required, or as to the suitability of a certain water supply, from the point of view of salinity, or poisons, as well as faecal pollution, and as to the sterilisation of both bulk and small water supplies.

(4) They were to investigate any outbreaks of disease, whether droplet, intestinal, contact, insect or animal borne or occupational.

(5) They were to be prepared to give a decision on the soundness of meat and other foods whose condition might be in question, and to inspect bakehouses, dairies, breweries, food preparation premises of all kinds, and cafes of all sizes.

(6) They were to conduct an effective liaison with the other services in their areas, and with the civil health authority, and the control of infectious disease in the civil population in occupied territory.

(7) They were to be responsible for the conduct of malaria surveys in many of the theatres of operation.

(8) They were to supervise the issue and use of disinfectants, rat bait, and anti-malarial equipment and stores, to ensure the most effective use of items in short supply.

(9) They were to lose no opportunity of research into new methods of sanitary improvisation so as to offset a shortage of R.E. supplies, especially in forward areas, and were to conduct practical tests of such things as insecticides, insect repellants, foot soaps, disinfectors, and so on.

(10) They were to be prepared to instruct officers and men of all and any rank in every aspect of hygiene and sanitation.

That is not a complete list, and takes no account of that headache under active service conditions—the monthly report—but it will suffice to indicate the variety of the work and its close association with the general public health of civil life.

But what a responsibility for many of those who went! Just imagine the feelings of the youngsters who joined up direct from full-time School and M. & C.W. appointments, or, as many did, direct from taking a D.P.H., and found themselves in command of field hygiene sections, or instructors at the Army School of Hygiene or Deputy Assistant Directors of Hygiene in a large area in an overseas—perhaps tropical—theatre.

Where a regular specialist officer understood procedure, knew what to do and how to do it, and had at the same time not only quite a wide epidemiological knowledge, but a practical experience in the prevention of infectious disease, so very important from the point of view of conservation of manpower—they, the emergency specialists, seldom had such advantages.

That they made good has already been placed on record, but many will not hesitate to admit how ill-prepared they were in regard to inspection of camps and billets, reconnaissance of water supplies and the selection of camp sites, food inspection, disinfection and disinfestation, liaison with the civil health authority, and all their other duties, including the guidance of the formation or area commander in all aspects affecting the health of his troops.

Many again found great difficulty in administering a Field Hygiene Section, having no previous experience of military procedure, and it says much for the sanitary assistants of all ranks that the regimental staff sergeant or administrative N.C.O. and the unit clerk could, in many of these units, cope with all the interior economy, leaving the O.C. and his team of sanitary inspectors free for technical duties, unworried by procedure of which they had little or no knowledge.

#### Opportunities for General Experience in Civil Public Health

It would have been quite impracticable in those early days of 1939-40 to stipulate that the potential hygiene specialist must serve for a period as a trainee. That was done later on, with good results, and the men who joined later had an easier passage altogether. To begin with, however, the demand was too great. Something, however, could, and should, have been done before they ever came in to the service. The medical officer of health had not helped in their preparation as, at least

in some cases, he might have done. In saying that, however, I want to make it clear that I myself went in with the advantage of some years of general public health behind me, while even in my School and M. & C.W. appointments I was privileged to investigate infection and take part in much of the general public health work carried on in those authorities.

Previous military training was a help to many of us, I know, but those of us who had been given opportunities by our civil chiefs had an immeasurable advantage. Why more had not been so privileged it is difficult to say. I can remember calling upon a medical officer of health who is a very big name in public health to-day, and being greeted with, "I suppose you are another of these newly qualified young men, come to teach me my job." By the time I had taken my coat off and smoked a cigarette with him, I think we understood each other, and there is no doubt he clearly understood the "new boy problem," if I may call it so. But he had done nothing to alleviate it. I knew one of his assistants well, and good man though he was, he had never had an opportunity to do anything but purely clinical work.

Now do not let it be said that I am preparing for another 1939 when I appeal to medical officers of health to give the assistant his head, and let him in on the general work of the department. I have yet to meet the sanitary inspector who does not like to go out with the assistant M.O.H., and how well they worked together in those field hygiene sections I have referred to. I am one of those who believe that by losing what we did in July, 1948, we have gained the opportunity to do more than we ever did before. There is scarcely any general public health problem to which we have the entirely perfect answer. Medical officers of health, let your assistants work on these problems. To quote Metcalfe Brown: "The not infrequent appearance of the unusual adds the spice of variety and leads us to investigate well beyond the immediate needs of the actual situation"; and later, "The future of preventive medicine depends on our constant attendance at the ever-spreading margin of knowledge, keeping in mind that much has been done, but much remains to do."

#### DENTAL AUXILIARY WORKERS\*

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In every area in the country there are indications of deflections of dental officers from the service, and more and more schemes are disintegrating. How can the break-up of the service be checked? It is true that when adequate remuneration is paid to dental officers the drift to the general dental service may be checked, but even when the salary conditions have improved it is doubtful whether it will be possible to attract sufficient dentists to our ranks to provide a comprehensive school dental service for the simple reason there are not sufficient dentists to meet the needs of the population.

It is imperative, therefore, that consideration should be given to ways and means of augmenting this already harassed service, and it is therefore right and proper that we should consider the question of the employment of auxiliary workers as a means to sustain the service for the children so badly in need of it.

There are four classes of auxiliary dental workers, but for our purpose I think we need only consider the school dental nurse and oral hygienist. With regard to school dental nurses there is a wealth of experience gained in New Zealand to which we have recourse through the published reports of the Dental Division of the New Zealand Health Department. Much information will be available regarding the work of the hygienists when the results of the experiment, which has been sponsored by the Ministry of Health, are known. There is, of course, ample evidence of their worth as has been given by dental officers who had the assistance of oral hygienists in the dental branch of the Royal Air Force during the war.

\* Paper read to the Dental Officers' Group, Society of M.O.H., London, October 22nd, 1949.

### School Dental Nurses

The inception of the school dental nurse system in New Zealand in 1921 was the subject of keen controversy for some time within the ranks of the dental profession, a large section of whom feared that a satisfactory school dental service could not be built up on such lines. Eventually the New Zealand Dental Association gave their formal approval, and it is clear from the information given by all observers on the spot that the work done by dental nurses is of a high standard, and any observations I shall make will be from the economic standpoint only.

The scope of their work is the same as is normally carried out by dentists engaged in children's dentistry, except that root treatments are not undertaken. They fill all teeth in the permanent and deciduous dentitions and it is stated that they habitually use the rubber dam technique when conserving incisor teeth and when carrying out contour restorations. They also undertake local anaesthesia for the extraction of teeth and in the treatment of painful cavities. In their two years' training they are also taught to do gum treatment, scalings and instruction in oral hygiene. The recent annual report of the Dental Division shows that a dental nurse's average output of fillings is in the region of 1,600, which is about the same as the yearly output of a dental officer. The scheme has been operating for 26 years and the ratio of dental extractions per 100 fillings has been reduced from 114.5 in 1922 to 6.03 in 1948, a remarkable achievement which shows that the scheme has been a great success.

It would appear from the 1948 report of the New Zealand Department of Health that a staff of 709, which included 202 student nurses and about 20 dental officers on administrative and instructional duties, were employed. The number of children under regular treatment was 233,981, and each trained dental nurse had to superintend the dental care of approximately 500 children. Six-monthly inspections and treatments were arranged. The average annual salary for a dental nurse, taken over a period of five years, was £340 per annum. This rate of remuneration is shortly to be increased. The present basis of annual remuneration of a dental officer in this country is therefore about three times that of a dental nurse, but he can apparently treat three times the number of children she can be expected to deal with as is shown in the Cambridge reports. If the remuneration for dental officers employed by local authorities were comparable to the Spens recommendations, there would probably be fewer leaving the service. Those who leave would, of course, not be lost to dentistry since, as they are fully qualified dentists, they are free to enter any other form of dental practice they so desire. When a dental nurse leaves the service the cost of her training, etc., can be written off as a dead loss since she cannot practise dentistry other than in the school dental service.

The following is a summary of the service given by the dental nurses and is quoted from information supplied by the New Zealand Health Department.

#### (a) Those who have resigned from the Service

From the inception of the scheme in 1921 until March 31st, 1949, 591 trained nurses have resigned. The average number of years of service (including two years' training) given by them was 7.88 years.

#### (b) Those still in the Service

The average total length of service given by 225 dental nurses who at March 31st, 1949, have given three or more years of service since qualifying and who are still serving was ten years (including two years' training period). In computing this, school dental nurses with less than five years' service have not been included as the nurses contract causes them to remain in the department for three years following their training period which is normally of two years' duration.

If the remuneration of dental officers were such as to encourage them to stay in the service, and the scope of their work broadened to give greater variation, they would normally enter at about 25 years of age and continue until 60 years. Their length of service would be 35 years. In the New Zealand scheme the number of nurses who would be expected

to resign under (a) during the 35 years would be about 766. The wastage therefore is high and represents a direct loss of dental operating power. This is the weakness of the New Zealand scheme.

In New Zealand the State bears the cost of the full training and maintenance of student nurses and of the instructors in the training schools. In this country the teaching staff for the dental schools is now the financial responsibility of the State, but the majority of students pay their own fees. It would therefore appear from the information given on the somewhat high wastage of personnel in the New Zealand scheme that it could not be adopted in this country as an economic basis, but let us consider the problem from the point of view of expediency. There are approximately 6,000,000 children in this country attending maintained and non-maintained schools. On the basis of 2,500 per dental officer, a staff of 2,400 officers would be required. This calculation is based on the fact that 72% of children in this country need treatment and that the acceptance rate for treatment would probably be about 84%. The maximum number of students qualifying from the dental schools each year is in the region of 340, which is about sufficient to make good the wastage of the register of 15,000 dentists of whom about 12,000 are in practice. It is difficult to see how the student capacity could be increased beyond the present number, at least for some years, in view of the existing building difficulties, the fact that there is a lack of teachers in dental subjects, and also there is a shortage of teachers in the basic sciences and in medical subjects. There is a general expansion in all the professions, and universities cannot meet this increased demand for specialist teachers. In the circumstances it is improbable that the annual output of newly qualified dentists will be materially increased for many years to come, and so there will not be enough dentists to man the school dental service for a considerable time, if ever. Associated with these difficulties is the fact that many dentists do not like treating children and cannot be attracted to the ranks of the school dental service however good the conditions of service may be. It is my view that now there is a comprehensive dental service set up under the National Health Service Act, dentists will not be attracted in sufficient numbers to the school dental service. The need for auxiliary dental workers is therefore obvious.

Some of the arguments put forward against the employment of school dental nurses are:

(a) That they might cause a redundancy of dentists because so many young women would wish to be trained as dental nurses.

(b) That parents would not like their children treated by operators who were not fully trained.

(c) That their work should be supervised, and therefore a number of dentists would be engaged in a supervisory capacity which, in itself, would be a wastage of dental man power.

With regard to (a), it is interesting to point out that although dental nurses have been employed in New Zealand for nearly 28 years, there is still a shortage of dentists in the Dominion, and recently a number of dental officers had to be recruited from this country to fill the gaps in the ranks of the qualified staff required for the organisation of the school dental nurses scheme. In the United Kingdom there are well over 45 million people, but only enough dentists to serve the needs of about 20 million. It is therefore highly improbable that the employment of dental nurses will ever cause a redundancy of dentists.

The student dental nurses are carefully selected and it is apparently difficult to obtain a sufficient number of the right type. A similar problem would exist in this country were dental nurses employed. There is, in the home country, much competition to obtain suitable women for the nursing profession and for the auxiliary medical services, and it is extremely difficult to get sufficient young women to fill all the vacancies. The school dental service in England and Wales would require a staff of over 12,000\* nurses to provide a service based on one

\* As the incidence of dental disease in the United Kingdom is not so high as in New Zealand, an allocation of 6,000 school dental nurses would be the more correct number for this country, i.e., one dental nurse to 1,000 children.

dental nurse to 500 children as in New Zealand, and I venture to suggest that it would be extremely hard to find and train such a large number of young women even over a period of many years. The chief opposition in the end would probably not come from the dental profession but from other authorities responsible for the training of nurses and auxiliary medical workers in that the dental profession would be accused of depleting the available pool of young women suitable for other professional training and employment. Accordingly, the fear of dilution by a large number of women rushing to enter the school dental nurses scheme can be ruled out as the law of supply and demand would have an inhibiting effect on the number of young women who could be trained as dental nurses.

With regard to (b), almost all parents of school children in New Zealand accept treatment, which indicates they value the work of the school dental nurses and appreciate their efficiency. Many independent observers who have examined treated children are full of praise for the high standard of work done by the school dental nurses. The parents have therefore no qualms about their children being treated by what may be called sub-dentists.

Finally, in connection with (c), this is not correct because the dental nurses work as independent units with the responsibility of diagnosis. They have, of course, the normal supervisory inspection of their work which should exist in any scheme.

With regard to the administration of the New Zealand scheme, it is of interest to point out that the school dental service, along with the school medical service, was eventually transferred from the Education Department to the reconstituted Department of Health, and a Director of the Division of Dental Hygiene appointed and a Division of Dental Hygiene within the Department of Health was formed. From the time when the change over to dental control was made, the service appears to have made particularly good progress.

#### Oral Hygienists

The introduction of a comprehensive dental service has made increasingly heavy demands on the dental profession. The Inter-Departmental Committee on Dentistry, under the Chairmanship of Lord Teviot, in considering how an adequate and satisfactory dental service for the population might be provided, recommended, *inter alia*, that

(1) A scheme for the training of oral hygienists should be initiated forthwith on such a scale as would provide an adequate test of their value.

(2) The function of oral hygienists should be limited to the scaling, cleaning and polishing of teeth and instruction to patients in the technique of oral hygiene.

(3) Their work should be conducted throughout under the responsible direction of the dentist, *i.e.* (a) he should examine the patient before the work is carried out by the hygienist; (b) he should give directions as to the treatment to be carried out; (c) he should see the patient after this has been completed; and (d) he should be readily available at all times.

The work of oral hygienists is strictly limited in scope in the school dental service; nevertheless, there are many children particularly in the last two age groups who need scaling and cleaning, and they certainly need instruction in oral hygiene. In those areas where there are orthodontists most of the children undergoing orthodontic treatment need frequent scaling and cleaning and instruction in the care of the teeth.

In the service provided by local health authorities under Section 22 of the National Health Service Act, their help would be invaluable. From dental examinations of women attending ante-natal and post-natal clinics in Middlesex, it was shown that 93% of those inspected require treatment, and all of them need scaling. If oral hygienists were available they could help the dental officer considerably by undertaking the time-consuming work of scaling and cleaning before the dentists commenced their operative treatment. It is the ideal preliminary to any surgical measure that the field should be thoroughly cleaned before the operation is commenced. This is particularly so in surgery, of course, and I suggest that it is equally important in dental surgery.

As the oral hygienists can render such useful service, I find it difficult to understand why there can be any opposition to their employment in the local health authority dental service. It is my view that the results of the Ministry of Health experiment, which will be known possibly in two years' time, will dispel any doubts as to their usefulness and ability to undertake fully the work for which they are trained. I envisage that before many years have passed oral hygienists will become established workers in the dental profession.

#### Minor Dental Work

In the Dentists Act of 1921 there is a section which provides for minor dental work being done by unregistered persons employed in the local authority service, the conditions governing such work to be laid down by the Minister of Health after consultation with the Dental Board. The conditions having been duly laid down by the then Board of Education in 1922, Circular 1279 was issued for the guidance of local education authorities. In 1932 the Minister of Health decided that in future, approval under this circular should not be given to any proposal involving the performance of inspection or applying or removing dressings and temporary fillings. It was not considered necessary, however, to approve a revised circular for issue to local authorities informing them of the altered conditions since it was believed, in the light of past experience, that the number of applications for approval to perform minor dental work would be very few. This expectation has been realised, and since 1922 there has not been a single application.

It will be seen from this information that local education authorities have already been given power to employ people such as oral hygienists for scaling and cleaning, but with regard to the work of the school dental nurses further consideration and approval by the Ministers of Health and Education will have to be given before they could be employed by local health and education authorities. It may mean, of course, that a slight amendment to the Dentists Act of 1921 may be necessary before school dental nurses can be employed by local authorities.

All of us here to-day are, I am sure, fully aware of the parlous state of the local authority dental services. I have now come to the conclusion that it will be extremely difficult to continue the service along existing orthodox lines, and we must face the fact that if there is to be a continuation of the local authority dental service for children, as I believe there should be, then we must consider the employment of school dental nurses to eke out the slender resources and as a solution to the staffing problems. I fully admit that I have previously resisted any suggestion of the employment in the school dental service of dental auxiliary workers, but in view of the acute staffing problems, and after studying the considerable amount of literature from the New Zealand Health Department and from my personal talks last year with Col. Llewellyn Saunders, the Director of the Division of Dental Hygiene, I am convinced that in recommending the employment of school dental nurses we shall enhance the value and importance of our service and that it can be achieved without any harmful effect upon the dental profession.

A full scheme of school dental nurses could not be operated for several years because of restrictions on building and the problem of selection and training. As the proposed employment of dental nurses would be a new departure, I feel it would be an advantage to have a pilot scheme in, say, two local authority areas if the Ministry of Education could persuade the New Zealand Health Department to second about 25 dental nurses to come to this country. The experiment should prove most helpful for it would give all concerned an opportunity to judge the merits or otherwise of the school dental nurses, *e.g.* work under conditions which exist here.

Most of you may have some misgivings regarding your position if dental nurses were employed. In my opinion, your sphere would become more important because many of you would be engaged in the more complicated dental treatments, there would be opportunities for you to take extensive refresher courses and specialise, say, in orthodontics, prosthetics and radiology. Moreover, the scheme for expectant and nursing mothers must be fully developed, and this work will always



be your province. Under Section 28 of the National Health Act it may be possible, subject to the approval of the Minister, to provide schemes of dental treatment for adolescents, for tuberculous patients discharged from sanatoriums and attending local health authority chest clinics; for children at occupation centres, for the adult mentally subnormal and for the chronic sick.

If the dental profession finally accepts the principle of the school dental nurses' scheme there must be adequate safeguard that their employment in the school dental service will in no wise mean a substitution for an equal number of dental officers on the approved establishment of each local health authority area. Their employment must be regarded as additional to the existing establishment as in each area this is far below normal requirements. The profession should also make it a condition of acceptance of the scheme that it should be centrally controlled in the interests not only of the profession but also of the nurses.

#### DISCUSSION

Dr. W. G. SENIOR opened the discussion, and asked that the problem might be viewed not in the light of the present unfortunate circumstances but rather as things were in 1939 before there was any drift from public to private practice. At that time the total number of dental officers was equivalent to somewhere about 1,000 whole time. That figure should be looked at in relation to the number calculated to provide a reasonable dental service for ante- and post-natal cases, pre-school and school children, which was about 5,000 whole-time dentists. Bearing in mind that there are approximately 10,000 dentists available for general dental service of whom 94% were actually in the service, it became apparent that with the virtual stationary Dentists Register the problem of meeting the needs of the priority service as to more than one-fifth was well nigh insoluble in terms of present dental manpower. It became necessary, therefore, to look at ways and means of enabling a public dental officer to carry out more work more efficiently by means of auxiliaries. Quite obviously, the first of these was a well-trained chairside attendant.

It was equally necessary that the dental officer should have a well-planned surgery and up-to-date equipment with which to do his work. The Teviot Committee had, amongst other recommendations, suggested a controlled experiment in the training and use of dental hygienists. The Government had accepted this recommendation and the Ministry was in process of putting it into operation. The full training course would commence in November. There had already been held a refresher course at the Eastman Dental Clinic for ex-R.A.F. dental hygienists. Their work on adults had been supplemented by special training in children's preventive dentistry, including instruction in the use of sodium fluoride. A certain number of these trained women had already been placed with local authorities in the public dental service.

Dr. Senior explained in detail the conditions under which they could be employed and gave some indication as to their course of training. Turning to the New Zealand dental nurses scheme, he said that from the various articles which had been published in the dental Press, and from verbal indications, there appeared to be little doubt that they were a success in that country. It was of particular interest that the scheme had started as a result of representations made by the New Zealand Dental Association to its Government at a time when that country was faced with much the same problem as that with which we were now faced. It was hoped to gain much more information about all aspects of the scheme. One very practical point which might be of interest was that the average cost per child, including the cost of the central training school, worked out at about £1 per head.

Mr. ENOS, who had been in New Zealand during the war, had had an opportunity of seeing some of the work done by the dental nurses. He had picked children at random and the standard was excellent. Private practitioners spoke well of the scheme and mothers and children liked it.

Miss KNOWLES explained how she had had an opportunity recently of speaking to the Matron of the New Zealand scheme who had been one of the original nurses. Most of their work was with the deciduous teeth, some was in the six-year-old molars, and now caries of the anterior teeth was rare. The rubber dam was used for fillings in permanent teeth and occasionally in deciduous teeth. Orthodontic cases were referred to general practitioners. Great care was taken never to frighten the children and the psychological approach was marvellous. The dental nurses worked without the help of dental attendants.

Mr. K. C. B. WEBSTER pointed out that in this country the dangers of unqualified practice were well known. The 1921 Act had been designed to protect the public. If there were to be any dilution, he

thought it should be in connection with a denture service. There were grave dangers in any kind of substitution service for the children.

Mr. J. FLETCHER thought the scheme was attractive in that it was probably the only way in which a full conservative service for the temporary teeth could be provided. But it should be a real auxiliary service and not a substitution one. The dental officer should make the diagnosis and refer appropriate treatment to the nurses. Such a scheme would in no way be less costly than the present one.

Mr. PEACOCK said that in the abnormal circumstances of the present he was in favour of auxiliaries. He could not understand why the dental profession was so touchy on this point.

Mr. K. BATTEN thought that dental nurses would give children the right approach to dentistry. Their first experience would not be to have a gas mask put over their faces and many deciduous teeth extracted.

Mr. J. F. A. SMYTH thought that diagnosis was an important point. The preliminary inspection should be done by dental officers. The New Zealand scheme was obviously first class, but there were differences between a substitution and an auxiliary service. He was sure we could, if we wanted to, have a wonderful auxiliary service. But the decision as to what the dental nurses should do and what the dental officer should do was a matter which the dental officer himself should decide.

Mr. J. V. BINGAY thought that the distrust of the New Zealand scheme, as it might be applied to this country, went down deeper. They knew the cheese-paring attitude of the local authorities. If the scheme were to be centrally controlled there would be much less doubt as to its value.

Mr. P. G. OLIVER said he was glad that Dr. Senior had said we should judge the problem against 1939 standards. Things were still appalling at that time. He was not opposed to the principle of auxiliaries. We spent too much time on the chores. But dental officers must have control and delegate the work themselves. He was glad it had been made clear that the service would not be cheaper.

#### THE VALUE OF SWABBING IN EPIDEMIOLOGICAL PRACTICE\*

I.—By C. MILLIKEN SMITH, M.D., D.P.H.,

County Medical Officer of Health, Northamptonshire

In opening this discussion, might I be allowed to say how glad I am that Prof. Robert Cruickshank has found time to give us the benefit of his expert knowledge and experience in "Public Health Bacteriology."

Obviously, our objective in swabbing is to enable us to detect

(a) The source or sources of infection, *i.e.*, the original case or cases;

(b) The patients who have contracted the disease from the original source;

(c) Those who are harbouring the responsible organism as incubationary, temporary or chronic carriers.

Swabbing, strictly speaking, means taking bacteriological specimens from ear, nose, throat, skin, rectum, etc., but I have included all bacteriological specimens in this note.

The well-known difficulty of interpreting the bacteriological results of swabbing arises from the fact that with at least two of the organisms commonly encountered, *viz.*, haemolytic streptococcus and *Staphylococcus aureus*, many persons, probably about 10%, harbour these germs in their upper respiratory passages.

In my view, the golden rule is "Don't swab until you know what you are swabbing for and what action you are going to take on getting the result." As an illustration, let me take the common case of an outbreak of bullous impetigo in a maternity home. The procedure I advise is that a blister from one of the affected infants is swabbed and the type of *Staphylococcus aureus* identified as closely as possible before nasal or throat swabs are taken from the nursing staff or mothers.

To make some brief comment on the practice to be adopted in dealing with the commoner infectious diseases:

\*Abridgements of papers opening a discussion by the County Medical Officers of Health Group of the Society, September 16th, 1949.

### Diphtheria

This disease is, fortunately, becoming of historical importance, but swabbing of all contacts is certainly desirable both in a day school and in an institutional outbreak.

### Scarlet Fever

The swabbing of contacts as a routine procedure is, I think, to be deprecated. One school medical officer I know used to indulge in an orgy of swabbing after the appearance of one or two cases of scarlet fever in a day school. The school nurses were instructed to examine all the contacts in the class and to swab those who appeared to have an injected throat. The results led to endless trouble as, for example, on one occasion when a girl whose throat swab yielded haemolytic streptococcus was found to live on a dairy farm, and consequently the milk had to be pasteurised in a great hurry. In dealing with scarlet fever, I think that the golden rule is to be strictly observed, namely, that the organism from the original case should be cultured and identified as closely as possible by modern methods, so that if it is later decided to swab any contacts the significance of the results obtained can be more accurately assessed.

The same remarks apply to streptococcal throat infections which are not accompanied by a rash, and also to puerperal infections in maternity homes.

### Whooping Cough

I have not swabbed school contacts for pertussis bacillus, but have used whooping cough plates in an attempt to deal with an outbreak in a residential nursery. In my limited experience, the value of whooping cough plates has so far been somewhat disappointing and I propose, in future, to use "per nasal" swabs mentioned by Prof. Cruickshank at the B.M.A. Conference at Harrogate.

### Typhoid and Paratyphoid Fevers

In taking specimens in cases of outbreaks of typhoid and paratyphoid, it is of extreme value, epidemiologically, to have the organism recovered from the original patient as closely identified as possible, although it may not at times be so essential to do this as in the case of scarlet fever and other streptococcal infections.

### Conclusion

As with modern advances in bacteriology the various organisms found in common infectious diseases can be more closely identified by grouping, typing, etc., the value of swabbing in practice will be enhanced.

II.—By ROBERT CRUICKSHANK, M.D., F.R.C.P., D.P.H.  
Professor of Bacteriology, University of London

When two or more cases of an identifiable infection such as scarlet fever, Sonne dysentery, or bullous impetigo, occur in school, nursery or maternity home, it becomes the responsibility of the medical officer of health to find, if possible, the source of infection and the mode of spread so that control measures can be taken to prevent further infection. To this end he will, if he is wise, enlist the co-operation of his bacteriological colleague in the public health laboratory as quickly as possible.

First it is essential, as Dr. Smith has pointed out, to identify the causative organism precisely. It is not enough to know that the haemolytic streptococcus causing scarlet fever belongs to Lancefield A, or that the staphylococcus causing pemphigus is coagulase positive. We must go further and determine the serological or phage type of these organisms. For this, pure cultures of the organism must usually be sent to a reference laboratory where these specialised techniques are carried out. Obviously, if we are to separate cause from effect, i.e., primary from secondary cases, action must be taken quickly before infection has spread through the community. Unfortunately, epidemiological investigation often begins too late, and this is a problem which deserves the close attention of the medical officer of health. Careful record keeping of illnesses in school, nursery and institution, with daily or weekly inspection by the

medical officer, will help to nip incipient attacks in the bud and avoid the more usual spectacle of the epidemiologist (if I may mix my metaphors) coming in on the crest of the wave and riding to glory on the downward curve. Indiscriminate swabbing at this late stage is often a waste of time and energy.

Before discussing examples of the value of swabbing, I should like to say how important it is that the swab should be properly taken, carefully labelled and transmitted to the laboratory as quickly as possible. A rectal swab should enter the rectum and be covered with faecal matter when removed; a throat swab should be used only after a good view of the fauces is obtained with the use of a tongue depressor and torch; and a nasal swab should be taken from the vestibule, the turbinates or the post-nasal space accordingly as search is being made for staphylococci, streptococci or *H. pertussis* respectively.

In recent years attention has been focused more on the nose than on the throat as a nidus of infection. *Staphylococcus aureus* is present in 40-50% of adult noses, and outbreaks of staphylococcal food-poisoning or bullous impetigo are now frequently traced to a nasal carrier of the epidemic staphylococcus with the hands acting as the intermediary vehicle.

It used to puzzle me that with so many opportunities for contamination of food with staphylococci from the nose via the hands of the food-handler, staphylococcal food-poisoning is relatively rare. The likely explanation has come from the typing of staphylococci since Allison has shown that apparently only two of the many staphylococcal phage types, viz., 6/47 and 42D are capable of producing enterotoxin. Thus, if an outbreak of staphylococcal food-poisoning occurs in a factory canteen the first requirement is to identify the staphylococci in the contaminated food and in the faeces of the infected patients. Too often this latter step is omitted by the medical officer or the sanitary inspector, partly because attention is concentrated on collecting various articles of food for bacteriological examination and partly because patients make a quick recovery from the diarrhoea and vomiting and are unwilling to supply specimens. Then, when the phage type of the infecting staphylococcus has been identified, the noses and hands of the kitchen staff should be swabbed and examination made for a carrier of the epidemic strain. Since staphylococci may remain viable for some time in dust, the kitchen dust should also be collected and examined. A similar procedure is carried out when one or more cases of pemphigus occur in a nursery, swabs being taken not only from contacts but also from baths, napkins, communal towels, ointment pots and the like.

It has long been known that the case or carrier of nasal diphtheria is a most dangerous focus of infection, and now there is convincing evidence that the heavy nasal carrier of haemolytic streptococci is much more likely to initiate an outbreak of scarlet fever or sore throat than is the throat carrier. J. E. Gordon, in 1932, showed that convalescent cases of scarlet fever with purulent discharge were the most common cause of "return" cases, and Colebrook, in 1933, found that the doctor or midwife who was a nasal streptococcal carrier was most likely to be responsible for cases of puerperal sepsis, but it was the work of Hamburger and his colleagues in 1945 which demonstrated clearly why the nasal carrier was so dangerous. By different tests they showed that the heavy nasal carrier disseminated 80 times more haemolytic streptococci than the corresponding throat carrier and that outbreaks of streptococcal infection in hospital and barracks could usually be traced to one of these carriers. We have confirmed Hamburger's claims in the investigation of a series of outbreaks of sore throat and scarlet fever in day and boarding schools and in nurseries. When such an outbreak is investigated early, it may be cut short by nasal swabbing of close contacts and isolating any nasal carrier who may or may not give a history of previous infection. Dust from desks, floors and blankets may be secondarily contaminated and may thus act as vehicles of infection (examples given).

Sonne dysentery is now an endemic infection in this country, affecting mostly children under five years, and is particularly apt to spread in day or residential nurseries. Notifications of dysentery rose from 1,941 in 1939 to a peak of

16,278 in 1945, after which there was a dramatic and unexplained fall to 7,870 and 3,761 notifications during 1946 and 1947 respectively. It may be that the rapid increase of notifications during the late war represented a widespread prevalence of Sonne dysentery which is often so mild that it is never reported, and that the subsequent fall was an index of a temporarily immunised population. If so, as the 1948 notifications of 5,479 suggest, we may expect further epidemic waves, and further trouble in the nurseries where, among young children, the infection may be quite severe.

The use of the rectal swab and new selective culture media has shown that in outbreaks of bacillary dysentery, symptomless and convalescent carriers may greatly outnumber cases. As the disease is highly infectious, detection and isolation of these carriers is often the best way of preventing spread, always provided that action is taken early. The occurrence of two or more cases of acute diarrhoea in a nursery is therefore an indication for bacteriological examination to determine the cause of the diarrhoea, and then if it is proven Sonne dysentery, to discover the carriers. From the primary cases it is preferable to obtain specimens of faeces so that search can be made for protozoa such as *Giardia*, as well as for bacterial pathogens. If the cause is bacterial, and outbreaks may be due to *Salmonella* as well as to *Shigella* organisms, material from the contacts is best obtained by rectal swabbing, which can be carried out on all children in a nursery during a morning visit. Children absent from the nursery with diarrhoea should have at least three consecutive rectal swabs before they are allowed to return. I should like here to issue a warning against undue glorification of our modern bacteriological methods which detect the ultimate dysentery bacillus in a specimen of faeces or diphtheria bacillus in a throat swab. Sparse carriers of pathogenic bacteria are not likely to be important foci of infection and sometimes too stringent precautions are recommended in dealing with such carriers. We still know far too little about the infecting dose of different pathogens, but from epidemiological evidence it seems likely that, for example, many more paratyphoid bacilli than typhoid bacilli are required to initiate enteric fever and similarly it needs many more *Salmonella* than dysentery organisms to cause gastro-enteritis. There is an urgent need for much careful epidemiological observation into the mode of spread of the common communicable diseases. The medical officer of health and the bacteriologist share this opportunity and responsibility.

## CORRESPONDENCE

ORGANISATION OF CHILD HEALTH SERVICES  
To the Editor of PUBLIC HEALTH

Sir,—With reference to your report of the first meeting between the British Paediatric Association and the Society of Medical Officers of Health, the version given of any contribution gives the opposite meaning to my argument from what was intended.

In my few comments on Dr. Helen McKay's paper I cited her statement "... In some areas the position appears to have deteriorated since July 5th, 1948 as a result of the effort of some local authorities to shift expenditure on to the exchequer." My comment to this was that the expenditure of local authorities was limited by the local rate levy and that it was no desire of many local authorities to shift financial responsibility for the health services on to the exchequer but that this trend was something which, in my view, had come directly out of the Act.

The statement that "It seemed to him (Dr. Clayton) that the only thing that had come out of the Act up to now was a desire to shift financial responsibility on to the exchequer" in the report is the antithesis of what was actually said by me. Secondly, Dr. McKay's paper (*Public Health*, December, page 37) expresses the hope that those practitioners engaged in the Local Authority School Medical and Maternity and Child Welfare Services will in future "undertake domiciliary work as paediatrically minded general practitioners." My comment was that if it was the intention of the planners for those doctors engaged in the public health services to be diverted to general practice in future, then I would plead with them to say so as soon as possible, since it would at least help to resolve the state of "animated suspension" which was overhanging the public health service at the present time.

Incidentally no mention was made of my comment that co-opera-

tion between the paediatric services and the local authority clinics in Coventry was a real joy.

Yours faithfully,

The Council House,  
Coventry,  
January 16th, 1950.

T. M. CLAYTON,  
Medical Officer of Health.

[We regret that pressure of space compelled a condensation of the discussion at the joint meeting which caused a misinterpretation of Dr. Clayton's argument.

By an error, Dr. H. Stanley Banks was described in a later part of the report as of the North-Eastern Hospital, instead of the Park Hospital with which he has been connected for 17 years.—*Editor, Public Health.*]

## BOOK REVIEWS

**The Examination of Waters and Water Supplies.** (Thresh, Beale and Suckling). 6th Ed. By E. Windle-Taylor, M.A., M.D., D.P.H. (Pp. 819, 52 illustrations. Price 70s. net). London: J. & A. Churchill, 1949.

It is indicative of the important status of a book when it comes to be known familiarly by an abbreviation of its title. The earlier editions of the present book, "The Examination of Waters and Water Supplies," by Thresh, Beale and Suckling, were known simply by the name of the first of the authors, namely, Thresh. When the book was last revised by Suckling in 1943, it continued to be known by that familiar expression, "Thresh," and it is perhaps hardly likely that the present revised edition, by Dr. Windle-Taylor, will be known in future by any other expression than the word "Thresh." Nevertheless, in revising such a treatise the present author has taken on an important job, and has done it well; and, particularly on the bacterial side, he has left the impress of his own personality. The book has for years been accepted as an authoritative manual by water works and civil engineers, medical officers of health, bacteriologists, analysts and works chemists, in fact, all concerned with water supplies. It has occupied an important place on the shelves of water examiners and bacteriologists since the date of the first edition; and with the increasing importance attached to the hygienic quality of water, this latest edition incorporating recent work will, undoubtedly, be welcomed by all and fully maintain its popularity.

At the author says in the preface, "The British public is entitled to a water supply which, besides being safe, is also of high aesthetic quality, being clear and bright, soft and free from taste and odour." There is no doubt that careful study of this volume will enable those responsible to overcome many of the problems involved in producing this high standard water supply. The adoption in the book of the expression "ml." for "c.c." and the expression of results in parts per million are in accord with modern practice. The analyst will appreciate some of the newer processes given for various determinations, in particular, those for traces of metallic impurities; but no doubt some of the empirical determinations like B.O.D. and albuminoid ammonia are as unchanging as some of the geological considerations given in another part of the book. As may be expected from the medical qualifications of the author, the chapters on bacteriology are especially authoritative, and the consideration of water-borne diseases has now been extended to a separate chapter devoted entirely to that subject.

The author was indeed honoured to be chosen to continue the work of the eminent authorities who were the authors of the earlier editions, but from the manner in which he has done his work he has fully justified his selection; and those for whom the book is a fundamental part of their equipment will be indebted to Dr. Windle-Taylor for placing in their hands such an extremely useful and up-to-date volume.

**Meet Yourself at the Doctor's.** By "MASS-OBSERVATION." With drawings by Ronald Searle. (Pp. 70. Price 3s. 6d. net). London: The Naldrett Press. 1949.

The anonymous but lynx-eyed and keen-eared corps of mass-observers have done some useful jobs of objective reporting in their time, and the present example, though on a smaller scale and concentrating on the practices of one or two doctors and the clientele of two welfare centres, makes good reading, immensely enlivened by the witty lines of Ronald Searle's drawings. It gives a convincing picture of the current work of the general practitioner, and under the title "Baby Service," pays a tribute to the happy, personal atmosphere of a well-run welfare centre contrasted with a not-so-good sample. There is also a revealing glimpse (from the patient's point of view) of a hospital bedside demonstration, but we should like to have had the mass-observers' impressions also of the outpatient departments.



## A COMPREHENSIVE INDUSTRIAL HEALTH SERVICE

*Memorandum of Evidence prepared by the Society of Medical Officers of Health for the Industrial Health Services Committee appointed by the Prime Minister.*

### Preamble

1. The Society of Medical Officers of Health welcomes the invitation to submit evidence on the subject under review. The Society, in accordance with a longstanding agreement for consultation on matters of mutual interest, has discussed this field with the British Medical Association. It will be seen that up to a certain point the views of the two bodies are similar, but the Society has thought it desirable to suggest a fairly detailed scheme of both central and local administration. The Public Health Service has, from the inception of legislation for the regulation of working conditions in factories, been concerned with at least some aspects of this field. The tendency of industry in recent years has extended from improvements in machinery and processes to attempts to improve the physical environment and efficiency of the worker. During the national awakening of concern with occupational safety and well-being, interest centred successively on abolition of the exploitation of juvenile labour, on preventing the spread of infectious diseases, on the health of women working in factories, on toxic hazards, industrial injuries and environmental conditions in factories and workshops. What was first known as industrial medicine gradually became known as industrial hygiene and more recently as occupational health. This change in nomenclature illustrates the change from interest in disease to interest in health and the prevention of disease. Occupational health to-day may be defined as that branch of preventive medicine which is concerned with the well-being of the citizen during the period of remunerative employment and in his working environment. It is primarily preventive in character and should no longer be limited to employees in factories, mills and mines but cover the whole population wherever employed.

2. Occupational health is a specialised branch of preventive medicine, and has as its main principles the promotion of healthy living and the minimisation of incapacity. The basic relationship between public health and occupational health is shown by the facts that many of the pioneers in this new field of medicine naturally graduated to the industrial side by way of public health, and that our universities train students studying for the Diploma in Industrial Health (D.I.H.) side by side with those studying for the Diploma in Public Health (D.P.H.). It seems reasonable, therefore, to advocate that the practice of occupational health should be locally administered by a public body well established in the field of preventive medicine, namely, the Local Health Authority. The Local (Sanitary) Authority would continue to watch environmental factors and should, in our view, have more definite powers of enforcement. (See paragraph 12.)

3. We propose in this memorandum to deal with the following points:—

(a) The present statutory functions of local authorities in regard to factories and workshops (paragraphs 3, 4 and 5).

(b) The needs of a comprehensive industrial health service linked with the National Health Service (paragraph 6).

(c) How far this service is being or can be provided by industrial undertakings themselves or should be supplemented by other means (paragraphs 7-11).

(d) The grounds for suggesting that this service can be most fully and economically provided by Local Health Authorities in conjunction with the other branches of the National Health Service, especially the General Practitioner Service (paragraphs 12-14).

(e) The link between school and industry (paragraph 15).

(f) The nature of the general supervision to be exercised by a Central Department (paragraphs 16 and 17).

### (A) Present Powers and Duties of Local Authorities

4. (i) Under the Factories Act, 1937, Part I, District Councils are charged (Section 8) with the enforcement of provisions as to sanitary conveniences in all factories; and as to cleanliness, overcrowding, temperature, ventilation and drainage of floors as respects any factory in which mechanical power is not used. (Section 1 of the Act, which covers removal of dirt and refuse, cleaning of floors, walls, etc., is enforceable in all factories by Factory Inspectors of the Central Department; as are Section 2 to 7 covering ventilation, lighting and other environmental details mentioned above, in factories in which mechanised power is used, i.e., the great majority.)

The District Council has to keep a register of all factories in its district in which it has to enforce any of these provisions. This in fact means a complete register in so far as the D.C. is responsible for the sanitary conveniences of all factories, whether they use mechanical power or not.

"District Council" by definition in the Factory Act means Council of a borough or county district.

(ii) Under the Factory Act, 1937, Part VIII, District Councils are charged with the supervision of "outworkers" and their powers extend (S. 111) to homework carried out in any place "injurious or dangerous to the health of the persons employed therein." This responsibility may be a considerable one (e.g., St. Pancras metropolitan borough has a list of 509 "outworkers" in its boundaries and Manchester has over 1,700 of whom 500 live outside the city boundaries, information being passed to the other L.A.s concerned).

(iii) Under the Public Health Act, 1936, it is the duty of the District Council to take action under Section 46 in order to secure provision of adequate sanitary conveniences in factories and work places. The sanitary conditions of workshops and work places are also governed by Section 92 of the P.H. Act, 1936, since statutory nuisances, i.e., inadequate ventilation, uncleanness, or the presence of noxious effluvia or overcrowding to the extent of being prejudicial to the health of those working in a factory, workshop or work place are to be dealt with by the Local Authority. This section, however, does not apply to a factory subject to Section 1 of the Factories Act.

5. It will be seen from the above that the present powers and duties of local authorities in relation to factories and workshops and to those who work therein are very limited, but it is believed that in the very large number of smaller factories where no medical officer is employed by the owners, the district council's Medical Officer of Health and Sanitary Inspectors are the only persons who take any sort of interest at the present time in their hygiene and working conditions.

It is known that Medical Officers of Health receive requests for help in the solution of health problems from many factory managers, who apparently have not considered asking the assistance of the Factory Inspectorate.

### (B) The Needs of a Comprehensive Industrial Health Service

6. In the view of the Society a comprehensive occupational or industrial health service should comprise the following main sections:—

(a) Environmental services, i.e., factory design, questions of cleanliness, heating, lighting, ventilation, sanitation and also conditions of work, having regard to the nature of the industry.

The industrial doctor should pay frequent visits to the various departments of a factory so that he can observe operatives at their work and note defects in posture, lighting, etc.

(b) Routine medical inspections of a preventive nature, i.e., intended to detect the first signs of disease including psychological disorders. The attainment and enhancement of physical and mental health can at the same time be emphasised. First-aid work can also be included in so far as early treatment of injuries often prevents serious disability later on.

(c) Advice on job selection including the use of school record cards where appropriate, and pre-employment and "change of employment" medical examinations.

(d) Health education with particular reference to the nature of the work.

(e) Special medical advice and research on hazardous occupations. (Routine inspections of human toxic hazards are at present statutorily carried out by the Appointed Factory Doctor).

(f) Arrangements for rehabilitation after illness or accidents.

(g) Medical supervision of welfare services, e.g., works canteens, home visitation, co-ordination with Local Authorities' day nurseries, domestic helps, etc.

### (C) How this Service is or Should be Provided

7. In considering how such a service can best be provided we must take into account the extent to which individual firms are already providing an adequate service. The Ministry of Labour's figures of 239 whole-time and 2,837 part-time industrial doctors would seem to show that only a small proportion of even the large firms are at present appointing their own medical officers. It is said also that workers are apt to be suspicious that a doctor appointed by the firm may be working in the interests of the employer rather than the worker. Generally speaking, most firms are too small to provide their own industrial medical service even by combination with other small firms.

Regarding need (a) stated in paragraph 6, except in large undertakings with a trained medical officer and other experts at call, there is no single authority except a large local health authority which can provide a staff of officers qualified to advise on the varied environmental factors, e.g., the Medical Officer of Health and his staff, the Borough or County Engineer, Architect, Analyst and so on.

8. Dr. Stuart Laidlaw (M.O.H., City of Glasgow) has described two pilot investigations carried out by medical officers of his depart-

ment which we consider of such interest in the present connection that we have attached them to this memorandum (Appendix I). The most significant fact emerging from his findings is the extent to which domestic and social factors outside the scope of the factory or workplace seem to be responsible for a state of sub-health. Here again, except in the largest undertakings with a Welfare Officer and staff, there appears to us to be no single existing organisation except the Local Health Authority which is in a position to bring to bear for the benefit of the worker and his family so many social aids and services, and further to help to ensure that the worker is given any necessary medical or surgical attention by his N.H.S. family doctor or the Hospital Service.

9. Regarding the recommendations for routine inspections at set intervals as well as environmental control, there is an extremely close parallel with the School Health Service, which is responsible for advising on matters of environment and sanitation including the design of schools, school furniture, lighting, ventilation, washing facilities, catering and so on. The School Health Service has statutory authority for routine inspections at set intervals throughout school life and for special inspection of cases presented by the teachers and school nurses. Next there is the duty of the Local Education Authority to see that treatment is obtained where it is necessary either *ad hoc* through the school health service or through the general health services. In addition the Handicapped Pupils and School Health Service Regulations made under the Education Act of 1944 require L.E.A.s to ascertain the children needing special education; the analogy in a factory service would be the existence of industrial hazards and disabilities and a scheme to fit those whose health is not entirely satisfactory into work which is suitable for them. (An extension of the sheltered workshops now provided for some of the severely disabled.) In the general health services provided by Local Authorities there is also provision for health education of the public which could be extended if desired into factories and workshops. A further analogy might be drawn from the medical services of the Armed Forces, which are in effect occupational services directed towards the operational fitness of specially selected groups.

10. The total number of factories in Great Britain covered by the Factories Acts is 243,769, of which about 200,000 employ less than 26 workers.\* [Dr. Laidlaw reports that in Glasgow there are 54 factories employing over 500 persons, 97 factories employing 200-500 persons, and no less than 5,895 factories employing under 200 persons—4,357 using mechanical power and 1,538 non-mechanised.] The extension of a comprehensive health service to other places of work such as offices, shops and restaurants would be a logical sequence. Only 4,499 factories of the total had (at May, 1949) any kind of medical service (other than statutory examinations of young persons).

A very large proportion therefore of the factories and workshops throughout the country are small works employing less than 200 persons and unlikely to make arrangements at their own expense for employing medical officers or nurses even on a co-operative basis with other small undertakings. The Factory Department of the Ministry of Labour has a limited medical (15) and lay staff, whose time is taken up in checking the industrial toxic hazards and minimum standards of safety, etc., laid down by the Act, and we give reasons below (paragraph 16) why the staff of a Central Department is not the appropriate one for providing a comprehensive health service of the sort envisaged.

11. Some large and prosperous firms do indeed provide an excellent service. But the fact that there are at present less than 240 doctors employed whole-time and only about 2,800 part-time by industrial undertakings (we do not possess information of the numbers of medical officers in the nationalised industries) indicates that this field has been barely touched so far.

#### (D) The Grounds for Placing Responsibility Upon Local Health Authorities

12. We recommend that local executive responsibility in this field should be placed on Local Health Authorities (County Borough and County Councils) rather than upon all Local Authorities, although at present non-county borough and district councils are among those with functions under the Factories Act. Since July 5th, 1948, many of the services which could be usefully applied in factories and workshops have become the responsibility of Local Health Authorities only, although environmental control is left with the Local Sanitary Authority whatever its size. In counties we consider that the District Councils should have definite powers and duties over not only sanitary provision in factories but over heating, lighting, ventilation, and so on. The County Council as L.H.A. would have a general supervision over these aspects and would be fully responsible for the personal health side.

13. The arguments in favour of making the Local Health Authori-

ties responsible for a comprehensive industrial health service may be summarised as follows:—

(i) The major Local Health Authority is the recognised centre of preventive medicine for its area. It has prestige gained from long establishment, forms an integral part of the life of the community, and relies for its success on its accessibility, as in the geographically changed countries the service is administered on a divisional basis.

(ii) It is a distinct advantage that the industrial medical officer (including the general practitioner employed part time in this capacity) should be a member of the staff of the Public Health Department, because he is less likely to be regarded with suspicion both by the employees and the management.

(iii) The local authority medical officer is an impartial investigator who has access *via* the M.O.H. to all departments and, through the close liaison which exists between the Public Health Department and the hospitals and out-patients clinics, he is enabled to make use of these services without delay.

(iv) A new route would be open to the general practitioner for the solving of his patients' medical and social problems *via* this service of his Local Health Authority. An increasing number of general practitioners already do sessional work for the Local Authorities Child Welfare and School Health Services, and we envisage that general practitioners with a special interest in industrial conditions, on a part-time basis, would form the main staff for the industrial service. Already the general practitioner relies on the Local Authority for the provision of such services as rehousing of overcrowded and tuberculous cases, domestic help, domiciliary midwifery and home nursing, as well as for assistance with the aged and infirm and the mentally ill or deficient—in fact, for practically every service which is not clearly a hospital problem and increasingly for those services which we understand by the terms "care and aftercare" under the N.H.S.A., 1946.

(v) Another advantage would be that an arrangement of this sort would ensure that the knowledge about young entrants to industry gathered by the Education Health Service would almost certainly be more fully brought to bear upon the early years of working life. (A link with the Armed Forces would also be important, in view of the withdrawal and return of workers as National Servicemen at an important age in their development.)

(vi) The Medical Officer of Health in his capacity as medical adviser to his Local Authority has a definite duty to advise the directors of the municipal undertakings with regard to the health and welfare facilities of their employees. (This also applies in the case of M.O.H.s of non-county boroughs.) He usually arranges the sick pay and superannuation examinations of municipal employees and the addition of one or two medical officers with industrial experience would permit him to form the nucleus of the new service. A start should first be made in the large cities and industrial counties, in which over 90 per cent. of all factories are situated. The Local Health Authority can use this service to raise the standard not only of the health of the citizens but to forge a link with its health-visiting, educational and general social service provisions.

(vii) A linking of the nursing staffs employed by Local Health Authorities and those in industrial nursing could not do otherwise than ensure economical use of trained nursing resources.

(viii) Such a scheme would permit the Local Health Authority to carry out research into many problems affecting the health of the worker, in conjunction with local representatives of the employers' associations, Trades Unions and Hospital Service.

(ix) When local Health Centres are provided (a responsibility of the L.H.A.) first-aid facilities for neighbouring factories could be provided there more economically than in individual works.

(x) In planning an Occupational Health Scheme on a national basis, heed must be taken of the number of doctors available to take part in the scheme. There are at present, and will be for a long time, too few industrially trained medical officers to provide a full-time service for all the industrial establishments in the country, even if the suggestion that several small factories combine to employ a full-time medical officer between them be adopted. We consider that one or two whole-time medical officers (see (vi) above) could as a first step survey the whole need of the area and the medical staff would be completed by the appointment of general practitioners to make regular visits to factories and workshops in their own districts. Therefore, on the basis of economy alone, advantage should be taken of the services of the Local Health Authorities who have already in existence all the basic administrative machinery required for such a service. Little additional expenditure would be needed. Local problems can best be solved by local people, who have knowledge gained by long experience on the spot and continuity of endeavour.

Such extension of the Local Authorities' Service to the people would be as natural as it is necessary, and would rapidly prove its worth to the individual, the community and the State.

\* Ministry of Labour and National Service document No. 7, of May 18th, 1949.

14. The National Assistance Act, 1948, placed the duty of caring for the aged and infirm on the Local Authority, so that to-day the Local Authority services may be said to cover the needs of the citizen from birth to school-leaving age, and again in later life after the period of useful employment has ceased. The intervening period is the span of the normal man's working life, but while the Local Authority is interested in his home environment, his food in the widest sense and, in some measure, his recreation, it has hitherto possessed very limited powers to assist in the betterment of his conditions of work. It is fundamentally unsound that this period of busy working years which forms the major portion of the life-span, with its strain and uncertainty, should be so poorly provided for. Apart from the decline in efficiency of the worker which results from this neglect, the nation has to deal with a vast amount of chronic illness in later life. This, of course, throws an additional burden on its overworked hospital system besides causing serious economic loss. The happiness and health of the citizen, which every political party is so anxious to safeguard, can best be ensured by providing services and assistance to prevent illness and avoid breakdown rather than by supplying palliatives to the permanently disabled.

#### (E) The Link Between School and Industry

15. We consider that this aspect deserves a section to itself in view of the immense importance of getting the young entrant into industry off to a good start and in a suitable job. The views of Dr. A. A. E. Newth (Senior School Medical Officer, Nottingham, and President of the Society's School Health Service Group) are given in Appendix II.

#### (F) The Nature of General Supervision by a Central Department

16. This Society has for many years urged that all central governmental activities in connection with health and disease should be concentrated in one Department and we are of opinion that this should logically be the Ministry of Health. We can see no reason, for instance, why the sanitary provisions of the present Factories Acts are enforceable by inspectors of the Ministry of Labour when similar provisions in other types of buildings are enforceable by the Local Sanitary Authority under the general supervision of the Ministry of Health. Further development and co-ordination by some central authority will be necessary before existing services can become comprehensive, before there can be broad integration between one service and another, and before a positive linking can be created between Occupational Health and the National Health Service. The subsequent supervision by the central department should be general and not detailed, on the analogy of the supervision exercised by the Ministry of Health and the Ministry of Education over the local carrying out of public health and school health functions. Detailed control by a central Department is not, in our view, satisfactory because of remoteness in accessibility. Factory health control should be localised on the analogy of domiciliary health services. The question arises of the present medical inspectorate of the Ministry of Labour. The Society considers that in principle these medical inspectors should be transferred to the Ministry of Health but maintain close relationship with the lay factory inspectors of the Ministry of Labour.

17. In general, there appears to be a lack of co-ordination and economy of medical manpower when one considers the "occupational services" at present provided and the Departments concerned:

- (1) Private arrangements by some factory managements.
- (2) Ministry of Labour Factories Department Medical Branch.
- (3) Ministry of Fuel and Power and National Coal Board—Medical service for miners.
- (4) Board of Trade—Medical services for seamen.
- (5) Ministry of National Insurance—Medical Branch (including Pneumokoniosis's Medical Boards).
- (6) Transport Executive—Railways medical staff.
- (7) Ministry of Supply—Medical staff for inspection of Ordnance Factories, etc.
- (8) National Dock Labour Board—Medical officers.

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December, 1949.

#### APPENDIX I

##### *Pilot Investigations in Glasgow*

Note by Dr. Stuart Laidlaw, M.O.H.

With a view to obtaining first-hand experience in this matter, two pilot investigations into occupational health have been carried out in Glasgow in recent months by two medical officers attached to the Glasgow Public Health Department. These men were

especially trained for this work, and possessed the Diploma in Industrial Health as well as the Diploma in Public Health. The basis of each survey was a complete analysis of the working environment and an estimation of the physical and mental capacity of each employee in relation to his or her job. The purpose of the investigations was to ascertain (a) particulars of the service required of the employees by the industry, (b) the repercussions of these services upon the health of the individual workers, and (c) an estimate of the time which a medical officer would require to devote to the supervision of the health and welfare of the employees.

The opportunity to undertake these investigations arose out of queries raised by employers with regard to the health of their operatives. In one instance, the subject of study was an old-established weaving mill in the East End of Glasgow employing 500 operatives, and in the other the Corporation Cleansing Department employing 2,400 persons.

#### *The Weaving Mill*

In the case of the weaving mill, investigations made on the atmosphere in the workrooms revealed major defects in the air movement and the supply of fresh air. Concentrations of carbon dioxide as high as 28 parts per 10,000 were detected and traced to the practice of recirculation of air in the interests of fuel economy. Lighting defects were also found: cloth examiners, for instance, having illumination of less than 2-foot candle-power at bench level. Recommendations made to and adopted by the management on these and other subjects, such as dust removal, seating arrangements and lavatory facilities, have resulted in a marked improvement in the working environment in the mill, with a reduction in the minor accident rate.

At the same time, a medical consultative service was made available to the workers, and in co-operation with the patient's doctor many defects found were able to be corrected. The co-operation of the general practitioners in the area was of the highest order, and the Public Health medical officer prescribed no treatment without reference to the patient's own doctor. In cases where hospitalisation or a specialist opinion was deemed necessary, the letter to the doctor contained an offer of help in securing the required service. In almost every instance the practitioner left the arrangements to the Public Health medical officer.

Help was given to the employees in social and domestic problems, and in this respect use was made of the appropriate Local Authority service. An outstanding discovery of the survey was the very real necessity for health education that was found. The employees, at first somewhat apathetic, soon began to take an interest in the improved facilities provided, and there is no doubt as to the success of the experiment. (A full report of this survey has been published in *The Medical Officer*, April 23rd, 1949, p. 173.)

#### *The Cleansing Department*

This Department, which is administered by Glasgow Corporation, employs 2,400 men who are distributed throughout the city in units of 200 or less. There are several divisional headquarters, each with a refuse disposal works and local depots from which the teams of refuse collectors operate.

The Medical Officer who undertook the review consulted records already in existence, material obtained from the medical examination of applicants for superannuation and sick pay schemes, and carried out a thorough survey of the processes and practices of the Department.

In this type of work, dust control and efficient mechanisation in the handling of refuse were found to be the prime factors in reducing sickness, absence and accident rates. Marked differences in these rates were found at the various depots, mainly due to the type of plant in use. The nature of the work and the outside conditions predispose to rheumatism, locomotor defects, cardiovascular degeneration, respiratory catarrh, dermatitis, trauma and sepsis. Medical examination of sections of these employees revealed such conditions as hernia, varicose veins, chronic bronchitis and peptic ulceration, with all of which heavy labour is incompatible.

Points of interest extracted from the report were:—

(1) Almost half the accidents involved injury to the upper extremity, while over one-third involved the fingers and hands. All workers are issued with gloves for protection but all do not wear them. The same criticism was made with regard to the wearing of eye goggles and dust masks. Most of the workers dispense with these, as they state that they curtail the field of vision and are uncomfortable to wear. It seems to me that further thought might well be given to both the design of gloves and the form which the protection for the eyes and upper respiratory passages should take.

(2) It was found that even qualified first-aid workers had little real understanding of asepsis, and that it was the introduction of sepsis into wounds of even the most trivial nature that caused the large majority of serious complications.

(3) Dermatitis, which is voluntarily notifiable, was a much less common occurrence than one would expect from the amount of handling of material and the dusty nature of the occupation.

(4) The medical officer engaged in this investigation undertook a job analysis of the task which each man was called upon to perform both on day and night shift, a method which makes it possible to fit each man into a particular job within his physical capacity.

(5) Owing to the nature of the work the development of chiropody facilities was urgently required.

(6) Health education in personal hygiene and in industrial hygiene would reduce the incidence of ill-health, but employees must recognise that, unless they are prepared to utilise the facilities provided for their comfort and safeguard their own interests in these matters, local authorities will naturally be unwilling to spend money in these directions.

(7) Improved first-aid facilities were found to be required, and the Director of Cleansing immediately implemented a proposal that at least two men trained in first-aid should be allotted to every works and depot.

(8) Cleansing Department employees ought to have double lockers, one for clean clothes and one for working clothes, and in addition spray baths should be provided so that at the end of the day's work they can return home clean. The Corporation of Glasgow is at present making improvements in this respect and is constructing a new plant at Polmadie capable of dealing with 600 tons of city refuse per day.

There is no doubt that these surveys have been successful in stimulating both employers and employees. They show that an efficient group industrial health service can be provided for the smaller units in industry by the major health authorities at little extra cost to the nation without setting up elaborate new and expensive services. The method suggested is that after a preliminary investigation by the Public Health medical officer supervision of the personnel should then be carried out on a part-time basis by a general practitioner. Our experience has shown that in this work liaison between the Public Health Department and the general practitioner service could be readily made.

#### APPENDIX II

##### *The Young Person Entering Industry*

By Dr. A. A. E. Newth (Senior School Medical Officer, Nottingham)

The young person on leaving school is still immature. He is growing rapidly both in his physical and psychological development and in most cases his education is incomplete. Whereas some young persons may be of almost adult proportions, not a few are little more than children, in some instances corresponding with a normal child of 12 or 13. He may have passed through many of the hazards of childhood more or less successfully, but at this age he is subject to new dangers. The School Health Service will have provided treatment for various conditions, but by this age it will often not have been completed and cannot have been expected to be completed until the physical and emotional condition of the child is sufficiently stabilised. This applies, for example, to certain eye conditions, orthopaedic conditions and child guidance work.

Up to the child's entry into school the medical supervision by the L.A. is voluntary. Directly he enters school it is compulsory and is complete, varying in intensity according to whether his condition is satisfactory or otherwise. If he falls into one of the categories of the handicapped he is re-examined at least once a year, and when under observation for a condition such as valvular disease of the heart he may have been examined very much more often. As he leaves school an attempt is made to direct him into a not unsuitable job by the transmission to the Youth Employment Officer of information about any serious defect. If sufficiently seriously disabled he may take advantage of the Disabled Persons Employment Act.

On entry into industry he is subject to examination by the Appointed Factory Doctor (formerly the Certifying Factory Surgeon), who is entitled to get from the School Health Service information about his condition while at school, although seldom is advantage taken of this. Under previous Factory Acts the Minister of Labour had the power to make regulations on this matter, but actually never did so.

If the young person is at a continuation school the medical inspection is continued, and this will become more universal when the County Colleges are established.

Otherwise after entering industry he is not liable to periodic medical inspection unless he is engaged in certain dangerous trades.

The health of an individual depends on many factors, among which the conditions under which he is living at home and learning at school or working in the factory are not the least important.

The condition of young men recruits for the South African War established the necessity for the medical supervision of the child

in the comparatively safe atmosphere of the school. There can be no doubt that the young person needs continued supervision while he is in the more hazardous and less easily controlled conditions of the factory.

The Education (Administrative Provisions) Act of 1907 established the principle of medical inspection by the School Medical (now Health) Service of the local education authorities, and this has continued, surviving even the National Health Service Act of 1946, and it would seem logical to claim that if a personal health service is to be extended after entry into industry it should be administered by the local authority, especially in consideration of the requirements to be fulfilled when the County Colleges are set up.

#### *Arguments for the Service being carried out by the Local Authority*

1. The School Health and other Services of L.A.s have proved their efficiency and are capable of still further developments.

2. It would ensure continuity of the work begun by the Maternity and Child Welfare Service and School Health Service of the L.A. in respect especially of:—

(a) Supervision in respect of health.

(b) Completion of specialised treatment begun by the S.H.S.

(c) Continued care of the handicapped, both the more severe and permanent and the less severe and temporary.

(d) Contacts with the home.

3. It would facilitate the compilation of information about the health of young persons and the organisation of research.

4. It would ensure that the work is done in the interests of the employee and that it is not subject to undue influence by industry.

5. A minimal standard of efficiency could be maintained by the central government with healthy competition between L.A.s for greater efficiency, and would not be subject to the good will or wealth of the industry.

6. It would overcome the difficult problem of the handing over of confidential information in the possession of the School Health Service to doctors outside the service.

7. The Central Advisory Council for Education (England) recommended that the statutory examination now being carried out by the factory surgeon should be transferred to the School Health Service. (*School and Life*, p. 90.)

#### VITAL STATISTICS (PROVISIONAL). ENGLAND AND WALES, SEPTEMBER QUARTER, 1949

Provisional figures for England and Wales published on January 5th, 1950, in the Registrar General's Quarterly Return\* show that the infant mortality rate and stillbirth rate for the September quarter, 1949, were the lowest ever recorded for any quarter.

Deaths of children under one year of age numbered 4,883, representing an infant mortality rate of 26 per 1,000 related live births, compared with 5,514 deaths and a rate of 28 per thousand in the same period last year, which was the previous lowest rate recorded for any quarter.

There were 4,104 still-births registered during the quarter, giving a rate of 21.9 per thousand live and still-births, compared with 4,447 and the previous lowest rate of 22.7 in the same period a year ago.

**Births.**—The number of live births registered was 183,278, giving a rate of 16.6 per 1,000 total population, which may be compared with 17.5, 20.0 and 19.8 in the third quarters of 1948, 1947 and 1946 respectively.

Of the births registered, 94,260 were males and 89,018 females, a proportion of 1,059 males to 1,000 females. The average proportion for the third quarters of the ten years 1939-1948 was 1,060 males per 1,000 females.

The number of illegitimate births, included in the total, was giving a rate of 9.2 per 1,000 total population. This compares with 101,545 deaths and a rate of 9.3 for the corresponding quarter of 1948, and an average death rate of 9.3 for the corresponding quarter of 1948, and an average death rate of 9.3 for the third quarters of the five years 1943-1947.

**Deaths.**—101,207 deaths were registered during the quarter, giving a rate of 9.2 per 1,000 total population. This compares with 101,545 deaths and a rate of 9.3 for the corresponding quarter of 1948, and an average death rate of 9.3 for the third quarters of the five years 1943-1947.

\* No. 403. H.M. Stationery Office, price 1s. net (or by post from P.O. Box 569, London, S.E.1, price 1s. 1d.).



Deaths from acute poliomyelitis and polioencephalitis (provisional total, excluding non-civilians) numbered 250 compared with 60, 83, 27 and 28 in the four preceding quarters.

The diarrhoea death rate for children under two years of age was 2.6 per 1,000 births (476 deaths) compared with 2.7, 2.8, 4.0 and 2.4 in the four preceding quarters.

**Natural Increase.**—The births registered exceeded the deaths by 82,071, the corresponding increases for the third quarters of the years 1946, 1947 and 1948 being respectively 112,642, 119,409 and 90,313.

**Marriages.**—The number of persons married during the quarter was 227,390, which was 6,136 more than the average for the corresponding quarters of the preceding five years 1944-1948, and represented a marriage rate of 20.6 persons married per 1,000 total population.

**Survey of Sickness.**—Out of 3,509 men interviewed, 2,186 reported having had some illness or injury in May and there were 1,478 consultations with doctors; out of 4,323 women interviewed, 3,167 reported having had some illness or injury in the same month and there were 1,856 consultations with doctors.

Illness or injury of some kind during a month in the period April, May, June was reported by 68.1% of all persons interviewed; the average incapacity among all persons interviewed was 0.90 of a day per month.

Among housewives (36.3% of the total interviewed), 76.5% reported having had some illness or injury during a month, compared with the general level of 68.1%.

## ANALYSES OF GENERAL AND MENTAL HOSPITAL STATISTICS

The Registrar-General has informed the Society of the following proposals:—

**General Hospitals.**—Experience of the war-time E.M.S. Hospital records scheme indicated that useful statistics could be derived from hospital records. The question of developing a national scheme for the analysis of such records was discussed early in 1945.

It was eventually agreed that an in-patient summary form should be tried out, and in 1948 this was done in a few hospitals. As a result of this experiment the form was modified, and it was decided to give it an extended trial in all teaching hospitals and in a number of other hospitals (including all hospitals in Leicestershire and Manchester). This extended trial has been in progress since the beginning of 1949. It is intended that a summary of information about a representative sample of all hospital patients should eventually be collected and analysed. The statistical information to be obtained in this way will be invaluable for efficient administration and much of it will undoubtedly contribute to the growth of medical knowledge. It is intended to tabulate the first six months' material and the results should be ready during the first half of 1950.

It is intended to tabulate the first six months' material and the results should be ready early in the New Year.

**Mental Hospitals.**—The Board of Control approached the Registrar General in 1947 to ask whether the General Register Office could undertake a more extensive analysis of Mental Hospital Statistics than had been done by the Board itself in the past. This was agreed. Since the beginning of 1949 all Mental Hospitals and Mental Deficiency Institutions in the Hospital Service have been sending to this Office index cards (specially adapted to the different circumstances of the two types of institution) for all patients admitted or discharged or who have died.

The first part of each card, completed on admission, gives the basic information about the patient (sex, age, marital state, home address, genetic history, etc.), as well as diagnosis on admission; the second part, which is completed on death, removal, transfer, or discharge, gives such information as period of stay, outcome, and diagnosis on leaving. Information about long-stay patients will also be asked for periodically.

Since home address is recorded, it will be possible to extract information about patients admitted to hospitals and institutions from each area in the country and to calculate rates of incidence.

It is expected that the first analyses of the 1949 figures will be ready during the second half of 1950.

## CLAIMS TO SICKNESS BENEFIT

The Registrar General has included in his Weekly Return\* a new table which will show, each week, information supplied by the Ministry of National Insurance as to the numbers of claims to sickness benefit made under the National Insurance Act during the last four weeks, with weekly averages for each completed month of the year, in each of the ten standard regions of England and Wales.

The figures show that the weekly averages so far in 1949 were the highest in the month of March in all regions except the London and South-Eastern region, where the highest month was February, and the Eastern region where the figures for those two months were the same. The July averages were the lowest in every region.

The figures for England and Wales as a whole given in the table are as follows:—

Weekly Averages		Week ended	
Jan.	157,800	Nov. 22	136,800
Feb.	180,100	Nov. 15	142,300
Mar.	185,400	Nov. 8	135,000
Apr.	114,400	Nov. 1	121,900
May	97,900		
June	83,700		
July	78,500		
Aug.	88,900		
Sept.	100,900		
Oct.	119,200		

## NUFFIELD FOUNDATION

### Fellowships for the United Kingdom

During the first six years of its work the Nuffield Foundation devoted nearly £465,000 to the award of fellowships, which formed one of the five major parts of the Foundation's programme. The other parts of that programme concerned the support of university research in the medical, the natural, and the social sciences, and the social and medical care of old people.

In the new programme adopted for the next five years the Foundation intends to continue and modify some of its existing fellowships schemes and to experiment with new schemes. The Foundation announces the continuance, with some amendments, of two schemes (for medical fellowships and travelling scholarships for farmers) which it has operated successfully over the last few years; and one entirely new scheme for the Home Civil Service. The Medical and Civil Service proposals are as follows:—

**Medical Fellowships.**—The Foundation's original scheme was designed to further the study and promotion of health as distinct from the diagnosis and treatment of disease; it was confined to the higher training of future teachers and research workers for child health, social medicine, industrial health, and psychiatry. Later the fellowships were thrown open to any field of medicine though still with preference for those who wished to train in the four subjects named. At the same time the Foundation offered a few fellowships aimed at the better training of those who wished to specialise in chronic rheumatism.

For the period ending March, 1954, the Foundation has decided on a unified medical scheme offering a number of fellowships open to highly qualified and promising medical men and women (usually between the ages of 25 and 35), who wish to train further for senior appointments in teaching or research. Preference will be given to those who wish to specialise in child health, social medicine, industrial health, psychiatry, and chronic rheumatism.

A sum of £50,000 has been provisionally allotted for this scheme. The tenure of the fellowships is from one to three years, and the value will be £900 to £1,300 a year, plus travelling expenses. Part of a fellow's period of study may be spent abroad.

**Travelling Fellowships for the Home Civil Service.**—Because of the increasing size and complexity of administration, the Nuffield Foundation has been turning its attention to the need to promote the training of administrators. The Foundation has offered, and His Majesty's Treasury has accepted, a five-year experimental scheme of travelling fellowships for members of the Home Civil Service. A sum of £22,500 has been allotted by the Foundation.

The purpose of the scheme is to enable civil servants—normally of the rank of Principal or Assistant Secretary, or the equivalent

\* The Registrar General's Weekly Return No. 47 for the week ended November 26th, 1949. H.M.S.O., price 6d. net (or post free from P.O. Box 569, London, S.E.1, price 7d.).

in the professional, scientific, and departmental classes—to gain first-hand acquaintance with the administration, problems, experiences, and opportunities of overseas parts of the Commonwealth, and possibly of Western Europe. (Study in the United States of America is excluded because fellowships for travel and study in that country are already provided by the Commonwealth Fund of America.)

The Nuffield Foundation hopes that, if the experiment should prove itself, it will be the forerunner of a Government-sponsored scheme on similar or larger lines.

**Other Schemes.**—Sufficient resources were set aside by the Foundation during earlier years for its fellowships and scholarships in dentistry to continue till 1954, and for its travelling awards in extraction metallurgy to continue till 1951; these schemes are therefore still current. The Foundation is now planning, and hopes presently to announce, other new schemes for the higher training of men and women of the United Kingdom.

## SOCIETY OF MEDICAL OFFICERS OF HEALTH

### NOTICES

#### CANCELLATION OF FEBRUARY ORDINARY MEETING

Owing to the inability of Dr. Joan Taylor to attend on February 16th, the proposed Ordinary Meeting for a discussion on Salmonella Infections is being postponed until after her return from the United States. It will probably be held on Thursday evening, April 20th, but a confirmatory notice will appear in our next issue.

#### MATERNITY AND CHILD WELFARE GROUP

A meeting of the above Group will be held at B.M.A. House on Saturday, February 4th, 1950, at 2.30 p.m., when Miss Beryl Watson (Children's Officer, Surrey C.C.) will give an address on "The Work of a Children's Officer."

**Post-Graduate Week-end, Cardiff.**—This is to be held from Friday, May 5th, to Sunday, May 7th, next. Details to follow.

KATHLEEN M. HART,

*Hon. Secretary.*

26, Langside Crescent,  
Southgate,  
London, N.14.

#### SERVICES HYGIENE GROUP

**President:** Air Commodore J. M. Kilpatrick, O.B.E., R.A.F.

A meeting of the above Group will be held in the Lecture Theatre, London School of Hygiene and Tropical Medicine, Keppel Street, Gower Street, London, W.C.1, on Friday, February 17th, 1950, at 5.30 p.m. Surgeon Captain D. Duncan, Director of Naval Hygiene, will be in the chair.

An address will be given by Surgeon Commander G. D. Wedd, R.N., of the Royal Naval Medical School, entitled "The Medical Aspects of Atomic Radiation."

Members of the Metropolitan and Home Counties Branches are cordially invited to attend.

G. M. FRIZELLE,

*Hon. Secretary.*

London School of Hygiene and Tropical Medicine,  
Keppel Street,  
London, W.C.1.

### REPORTS

#### ANNUAL GENERAL MEETING

The Annual General Meeting was held in the Hastings Hall, Tavistock House, Tavistock Square, London, W.C.1, on Thursday, November 24th, 1949, at 5 p.m. The President was in the chair.

Having confirmed the minutes of the last Annual General Meeting, the meeting received the Annual Reports of the Council, the Honorary Treasurer (Dr. James Fenton) and the Editor of *Public Health* for the session 1948-49 (as printed in *Public Health*, November, pp. 25 to 29) with the amendment, in the Council's report, of the deletion of Dr. Mearns Fraser from the list of members whose deaths occurred in the preceding session. The Balance Sheet and Income and Expenditure Account were also received. Thanks were accorded to the Hon. Treasurer for his services.

The Auditors, Messrs. Deloitte, Plender Griffiths & Co., were re-elected for the session 1949-50.

The following candidates having been duly proposed and seconded were then elected as Fellows:—

Allison, Victor Douglas, M.D. (BELF.), D.P.H.; Burgess, Anne, M.B., CH.B., L.D.S.; Burton, Lucas John Harmsworth, B.A., M.R.C.S., L.R.C.P., D.P.H.; Guild, Alexander Brown, M.B., CH.B. (EDIN.), D.P.H., D.L.H.; Guymer, Ronald Frank, M.A., M.D. (CAMB.), D.P.H.; Hal' James William, M.D., B.S. (DUNELM), B.H.Y., D.P.H.; Tartison, William, M.D., B.S. (LOND.), M.R.C.P., D.P.H., D.T.M. & H.; Longbottom, Donald, M.B., CH.B. (MANCH.), D.P.H.; McWilliams, Lionel Francis, M.B., B.Ch. (BELF.), D.P.H.; Prothero, Ruth, M.D. (LEIPZIG), L.R.C.P. & S. (EDIN.), D.C.H.; Smith, Robert Arthur Gordon, M.B., B.S. (LOND.).

Several nominations for the next ensuing election were received.

The next business was the election of the following as fully paid Life Members on the recommendation of the Council and their Branches:—

**Home Counties Branch.**—Dr. W. A. Bullough, C.B.E. (formerly C.M.O.H., Essex). Joined the Society 1946.

**Southern Branch.**—Dr. A. E. Drutt (formerly A.C.M.O.H., Hants). Joined the Society 1943.

**Welsh Branch.**—Dr. H. R. Tighe (formerly M.O.H., Swansea C.B.). Joined the Society 1920.

The meeting then adjourned.

### EAST ANGLIAN BRANCH

**President:** Dr. S. T. G. Gray (Deputy County Medical Officer, East Suffolk).

**Hon. Secretary:** Dr. A. J. Rae (Deputy County Medical Officer, West Suffolk).

A meeting of the Branch was held at the City Hall, Norwich, on Saturday, October 22nd, 1949, at 3 p.m.

The President-elect, Dr. S. T. G. Gray, was installed by the retiring President, Dr. Hilda Hay.

Dr. Ruddock-West expressed to Dr. Hay the Branch's appreciation of the work which she had done in the area, from which she was retiring on marriage, and he extended to her the Branch's good wishes for her future happiness.

#### The Tuberculosis Service

Dr. C. P. Hay, Deputy Senior Administrative Medical Officer, East Anglian Regional Hospital Board, gave a very interesting talk on "The Future Development of the Tuberculosis Service in East Anglia."

**Out Patient Clinics.**—He explained that the Region had been divided into nine areas, each based on a main or central clinic, with sub-clinics to serve outlying areas. The clinics had been chosen because of convenience and accessibility for the patient and the areas corresponded roughly to: Cambridge, Hunts and Isle of Ely, Peterborough and District, West Suffolk, South-East Suffolk, Yarmouth and North-East Suffolk, East Norfolk, West Norfolk, and Norwich, but Local Authority boundaries should no longer prevent a patient from attending the most convenient clinic. The main clinics were or would be established in close association with hospitals providing first-class x-ray and screening equipment and access to full laboratory facilities. The physician-in-charge would be assisted by medical, nursing, medico-social and clerical staff, etc. A close liaison should be maintained with the Local Health Authority in order to keep clinical, environmental and welfare services closely integrated. The sub-clinics should be equipped with x-ray and screening apparatus to allow of artificial pneumothorax refills being carried out there, and Dr. Hay named from two to five hospitals in each area at which it was intended that sub-clinics should be established.

**Residential Accommodation.**—He estimated that, excluding non-pulmonary and surgical cases, 144 additional beds were required for the treatment of early and intermediate cases in the Region. 200 additional beds for advanced cases, and 40 additional beds for children. It was hoped that the 95 beds at Ipswich Sanatorium would soon become available for early cases, and that blocks to accommodate 50 female patients might be erected at Kelling Sanatorium. Dr. Hay named seven isolation hospitals and five ex-public assistance institutions scattered throughout the Region at which it was suggested that the 200 extra beds required for advanced cases could be made available near the patients' homes. The reopening of Normanston Sanatorium for children only would provide the 40 additional beds for this type of patient, but this was not considered to be of such priority as the provision of beds for adults. It was proposed to provide the beds urgently needed for thoracic surgery by increasing the present accommodation for such cases at Papworth and Kelling as soon as possible. Accommodation for pregnant women would continue to be available at White Lodge Hospital, Newmarket. Treatment of non-pulmonary tuberculosis should be considered in conjunction with that of orthopaedic surgery generally, and the possibility of reopening 205 beds at St. Luke's Hospital, Lowestoft, is under consideration at the

present time. It was also suggested that two houses, each accommodating approximately 25 patients of one sex, should be provided for convalescent cases.

After tea discussion continued until, owing to the time, the meeting had to be terminated, the main subjects being rehabilitation and the advisability or otherwise of employing certain health visitors whole-time on tuberculosis work instead of combining it with other health visiting duties. Dr. Hay stressed the need for a Health Visitor to attend at the chest clinics, and several members spoke in support of this, although it was pointed out that in rural areas where it might not be practicable to employ specialist Tuberculosis Health Visitors, many of the advantages of the attendance of a Health Visitor would be nullified.

With regard to rehabilitation, members were agreed that the establishment of factories in large towns would be of little assistance to patients living in a large part of the Region, as they would probably be unwilling or unable to move to the towns in which the factories were situated. Comparison with the employment of blind persons was made, and attention was drawn to the smallness of the amount which many of them earned by working in their own homes. Dr. C. P. Hay spoke of the beneficial effect on the morale of the patient who was able to earn even a small sum.

The meeting expressed great satisfaction on hearing that Dr. Mayon-White had been appointed as a Children's Physician in the Region, and it was decided to invite him to address the Branch again at an early date.

A meeting of the Branch was held at the Guest House, Brome, near Liss, on Saturday, December 10th, 1949, at 3 p.m.

Dr. Laird, Venerologist at East Suffolk and Ipswich Hospital, addressed the meeting of his experiences at the recent Conference in America on the International Control of V.D., giving some indication of the extent of the problem in the United States of America and of the methods in use there to persuade people to seek treatment and to control the spread of the disease. Various propaganda material, such as story-telling pamphlets in pictorial form, was on view, and a gramophone record, somewhat resembling a negro spiritual, was played over to illustrate the type heard in drug stores.

Dr. Martin of the Public Health Laboratory Service proposed a vote of thanks to Dr. Laird for his interesting address, and the President was pleased to be able to reassure the members that Dr. Laird would not be leaving the area, as had been stated on the Agenda for the meeting.

It was decided that the next meeting of the Branch, at which Dr. Mayon-White will speak on "The Co-ordination of the Work for Child Health in East Anglia," should be held at Brome on February 11th, and that Superintendent Health Visitors and Supervisors of Midwives should be invited to be present.

#### HOME COUNTIES BRANCH

*President:* Dr. G. Hamilton Hogben (M.O.H., Tottenham and Hornsey M.B.s., Area M.O., Middlesex).

*Hon. Secretary:* Dr. J. Maddison (M.O.H., Twickenham M.B., Area M.O., Middlesex).

A meeting of the Branch was held at 3 p.m. on Friday, October 14th, 1949, at the London School of Hygiene and Tropical Medicine. The retiring President (Dr. N. Chadwick) took the chair at the commencement and 24 members attended.

*Installation of President.*—Dr. Chadwick referred to the career of the President-elect, Dr. G. Hamilton Hogben, and proceeded to invest him with the badge of office. Dr. Chadwick then vacated the chair in favour of Dr. Hamilton Hogben. The President gave an excellent address entitled "The Transitional Stage." In proposing a vote of thanks to the President, Dr. Williams, of Barking, hoped that it would be published in *Public Health*. This was seconded and carried unanimously.

#### (i) Admission to Hospital of Maternity Cases

It was reported that a letter dated July 29th, 1949, had been received from the Executive Secretary of the Society, setting out the recommendations of the Maternity and Child Welfare Group regarding admission to hospital of maternity cases, viz.:—

1. That case selection, on social grounds, should be made by the Health Authority staff.

2. That it should be a principle that the Midwife, and not the Health Visitor, should decide on the suitability or not of home conditions.

3. That "Tidy Administration" must be subordinate to local circumstances.

4. That the Society might collect more information on what is occurring in different areas.

5. No recommendation to the Ministry of Health before further information is obtained.

After very careful consideration the Hon. Secretary was instructed to forward the following comments of the Branch on the above recommendations:—

1. That case selection, on social grounds, should be made by the appropriate Medical Officer of Health.

2. That the appropriate Medical Officer of Health should decide on the suitability or not of home conditions.

3. No comment.

4. No comment.

5. Agreed.

#### (ii) Duties of Medical Officers of Health

It was reported that a letter dated July 29th, 1949, had been received from the Executive Secretary of the Society, requesting consideration and comment upon a resolution passed at a joint meeting of the County and County Borough Groups with regard to the duties of Medical Officers of Health and their place on Local Executive Councils and Hospital Management Committees.

It was resolved—

That in the opinion of the Home Counties Branch, County and County Borough Groups, after receiving the information set out in the resolution, should forward it to the Non-County Boroughs for consideration and comment before any action is taken thereon.

*Hon. Treasurer's Balance Sheet.*—The Balance Sheet for the year ended September 30th, 1949, was approved.

#### METROPOLITAN BRANCH

*President (1948-49):* Dr. J. A. Struthers (M.O.H., Holborn Met.B.). (1949-1950) Dr. F. R. O'Shiel (M.O.H., Stepney Met. B.).

*Hon. Secretary:* Dr. F. M. Day (M.O.H., Hammersmith Met. B.).

A meeting of the Branch was held at 5.15 p.m. on Friday, October 14th, 1949, at the London School of Hygiene and Tropical Medicine, Keppel Street. The President and 35 other members of the Branch attended.

*Death of Dr. Harry Smith.*—The Chairman referred to the recent death of Dr. Harry Smith, a member of the Branch Council, and expressed the feeling of loss felt by every member of the Branch. Dr. Struthers paid tribute to the services rendered to the Society by Dr. Smith and to his work in the interests of public health generally. It was unanimously agreed that a letter of condolence be sent to Dr. Smith's relatives.

*Installation of President.*—The retiring President, Dr. J. A. Struthers, thanked the Branch for the support that had been given to him during his year of office. He then installed Dr. F. R. O'Shiel as President for the ensuing year and invested him with the Badge of Office. Dr. O'Shiel expressed his thanks to the members for electing him as President.

*Thanks to Retiring President.*—Dr. James Fenton referred to the excellent and untiring services rendered to the Branch by the retiring President, Dr. J. A. Struthers, and asked that an item be included in the Agenda for the next meeting to enable the thanks of the Branch to be more fully expressed.

"The Public Health Laboratory Service in London."—Professor G. S. Wilson, Director of the Public Health Laboratory Service, Medical Research Council, addressed the meeting on "The Public Health Laboratory Service in London."

He outlined the history and growth of the Public Health Laboratory Service throughout the country; the present position in London; and the plans for future development. He gave a résumé of the scope of the work undertaken by the Laboratory Service and particulars of the facilities available to Medical Officers and others in the Health Service.

A general discussion ensued in which Drs. King, Smithard, Struthers and others took part. A number of questions relating to the service were put to Professor Wilson, who answered the various points raised.

In moving a vote of thanks to Professor Wilson, Dr. A. B. Porteous made a plea for closer co-operation between the Laboratory Service of the Medical Research Council and the Teaching Hospitals.

The vote of thanks was carried with acclamation.

*Duties of Medical Officers of Local Health Authorities.*—A communication from the Executive Secretary, asking for the comments of the Branch upon a resolution passed at a joint meeting of the County and County Borough Groups, dealing with duties to be allotted to the Medical Officer of Health of a Local Health Authority and his Assistants, was considered.

In view of the limited time available for discussion and the importance of the subject, it was agreed that the matter be referred to a special meeting of the Branch to be held on Thursday, October 27th, 1949, at 5.15 p.m.



### NORTHERN BRANCH

*President (1948-49):* Dr. W. V. S. Macfarlane (Phys. i/c V.D. Dept., Newcastle General Infirmary).

*(1949-50):* Dr. E. F. Dawson-Walker, (M.O.H. Easington R.D.)  
*Hon. Secretary:* Dr. W. S. Walton, G.M. (M.O.H., Newcastle-on-Tyne C.B.).

The summer meeting of the Branch was held at Glaxo Laboratories, Barnard Castle, at 12 noon on Thursday, July 14th, 1949. Dr. A. S. Hebblethwaite was in the chair in the absence of the President, and 18 members and two visitors also attended.

*President of the Branch 1949-50.*—It was unanimously agreed that Dr. E. F. Dawson-Walker be elected President of the Branch for the session 1949-50.

*Vice-President.*—On the motion of Dr. Raine, seconded by Dr. Pierce, Dr. M. Dewell was unanimously elected Vice-President of the Branch.

*Honorary Secretary and Treasurer.*—Dr. W. S. Walton was unanimously re-elected.

*Branch's Representative on Council of Society.*—Dr. A. S. Hebblethwaite was re-elected.

*Representatives on the British Medical Association.*

(1) Dr. J. Grant and Dr. W. J. Pierce were re-elected to serve on the Council of the North of England Branch, B.M.A.

(2) The election of two representatives on the Executive Committee of the Newcastle-upon-Tyne Division of the British Medical Association was deferred until the next meeting.

*Representatives of the North of England Branch, B.M.A., on the Council of the Branch.*—It was decided to invite the North of England Branch, B.M.A., to elect two general practitioner representatives.

*Tuberculosis Group Committee.*—Dr. J. V. Walker was elected as the Branch's representative.

*Hospital Management Committee.*—On a motion by Dr. Grant, seconded by Dr. Elder, the Honorary Secretary was instructed to forward to headquarters the following resolution:—

"That the Northern Branch views with considerable apprehension the increasing amount of lay officer control in the Hospital Management Section of the National Health Service, and asks the Council to register a strong protest against the passing over of the Medical Superintendent's duties to lay officers."

*Tour of Glaxo Works.*—At the conclusion of the meeting the members were entertained to lunch at the Hotel by the management of the Glaxo Laboratories, Ltd., Col. L. A. Gullick, General Manager, presided.

During the afternoon the visitors from the Branch were divided into three parties and toured the extensive works associated with the production of penicillin. The chief impressions gained were, firstly, the general efficiency of the laboratories and process departments, secondly, the amount of work done, and lastly, the excellent standard of factory hygiene (ventilation, cleanliness, washing facilities, etc.), even in places away from the aseptic technique of the actual handling and preparation of the penicillin products.

A meeting of the Northern Branch was held in the Board Room, Elswick Grange, Newcastle-upon-Tyne, 4, on Friday, October 21st, 1949, at 4.30 p.m.

*Hospital Management Committee.*—The Honorary Secretary reported that the Resolution with regard to lay officer control of hospitals passed at the last meeting had been referred to Headquarters to a special Sub-Committee of the Society set up to deal with the question of hospital administration.

*Scope of National Arbitration Tribunal.*—The Honorary Secretary reported a reply from the Executive Secretary, which stated that, to deal with the question of salaries, what was proposed was not the National Arbitration Tribunal under Emergency Regulation 1305, but a reference to a Court of Conciliation under the Industrial Disputes Act, or a special Committee of Enquiry set up by the Minister on any matter where the Management and Staff sides cannot agree. Always subject to the overriding Authority of Parliament.

*Resignations.*—The Honorary Secretary reported the resignations of Dr. E. G. Brewis and Dr. A. G. Newell from the Society.

*Representatives of North of England Branch of British Medical Association.*—The Honorary Secretary reported that Dr. H. H. Goodman and Dr. H. L. Taylor had been elected as the representatives of the North of England Branch of the British Medical Association on the Council of the Northern Branch.

*Election of Representatives to Newcastle-upon-Tyne Division of British Medical Association.*—It was agreed that Dr. W. S. Walton and Dr. Wilson Minns be elected as the Branch's representatives on the Newcastle-upon-Tyne Division of the British Medical Association.

*Duties of Medical Officers of Health. Statutory Place on Local Medical Committees and Hospital Management Committees.*—The meeting had before them a letter from the Executive Secretary forwarding a Resolution of the County and County Borough Groups on the duties of Medical Officers of Health, and asking for the Branch's consideration and comment.

The first part of the Resolution was discussed at length. Drs. Grant, Walker, Hebblethwaite, Elder, Tilley and Walton expressed their views on the past and present duties of the Medical Officer of Health, and his future place in the structure of the National Health Service.

It was eventually agreed that each Medical Officer of Health in the Branch be asked to submit to the Honorary Secretary a list of his duties as they now exist, including those delegated to him by the Authority, those duties which he has lost, and his opinion as to what new duties should come within his scope.

A Sub-Committee, consisting of the President, the Hon. Secretary and Drs. Hebblethwaite, Grant, Tilley, McCracken, Elder, J. V. Walker and Hopper, was elected to examine the views submitted and to forward a consolidated statement to Headquarters as the opinion of the Branch.

Dealing with Section (2) of the resolution, Dr. J. V. Walker moved that the Branch agree to support it. Dr. Elder, however, doubted the wisdom of having a statutory place on the Hospital Management Committee; Drs. Tilley and Wilson also spoke against it, and moved that the Branch did not agree. This was carried.

*Admission to Hospital of Maternity Cases.*

The Honorary Secretary submitted a letter from the Executive Secretary, forwarding recommendations from the Maternity and Child Welfare Group of the Society with regard to the admission to hospital of maternity cases and asking for the Branch's comments.

The recommendations were considered in order and the following decisions arrived at:—

(1) Agreed. Dr. Tilley stated that if the Branch did otherwise, the hospitals would probably set up their own health visiting staff.

(2) The Branch did not agree. Views were expressed by Drs. Grant, Wilson and Walker that Health Visitors and Midwives should work in collaboration and that there should be no rivalry between them. The last word was always with the Medical Officer of Health or the Chief Health Visitor.

(3), (4) and (5) The Branch declined to comment on Nos. 3, 4 and 5, being doubtful as to the meaning of the Resolutions.

*Report of Branch's Representative on Council.*—Dr. Hebblethwaite reported on matters which had been before the Council of the Society at its last meeting.

*Prevention of Tuberculosis. Use of B.C.G. Vaccine.*—Dr. Hebblethwaite reported on the recent joint conference between the National Association for the Prevention of Tuberculosis and the Society of Medical Officers of Health, with regard to the use of B.C.G. Vaccine. He stated that Local Authorities were being asked to consider the provision of isolation accommodation for children being treated and asked members to support the idea of Preventoria in the area.

### NORTH-WESTERN BRANCH

*President:* Dr. John Yule (M.O.H., Stockport C.B.).

*Hon. Secretary:* Dr. J. S. G. Burnett (M.O.H., Preston C.B.).

A meeting was held at the Town Hall, Stockport, on Friday, October 14th, 1949. Fifty-six members and guests were welcomed by the Mayor of Stockport, Alderman Leonard E. Lowe.

It was resolved that:—

(a) The resolutions of the County and County Borough groups (i) concerning the setting out of lists of duties of medical officers of health and their assistants and (ii) asking the Minister of Health to decree a statutory position on local executive councils and hospital management committees for local health authority medical officers of health be agreed; and that (b) the recommendations of the M. & C.W. Group regarding the arrangements for admission to hospital of maternity cases be agreed, subject to the two following amendments:—(i) In the first clause substitute "the staff of the medical officer of health" for "the health authority staff." (ii) In the fourth clause substitute "should" for "might."

It was agreed to nominate, as whole-time members of the Public Health Service, Drs. Swan and Gawne to be the Branch representatives on the Merseyside Branch Council of the British Medical Association.

*Installation of President and Presentation to the Retiring Hon. Secretary.*—The retiring President then inducted Dr. John Yule to the office of President, and Professor Topping and Dr. Galloway expressed the thanks of the Branch for the admirable services rendered by Dr. Innes during his period of office. Dr. Yule expressed his gratification that the first duty he should be called

upon to carry out as the President of the Branch should be the handing over of a cheque, contributed to by 128 members, to Dr. J. E. Spence, as a tangible token of the regard felt for him by the members of the Branch on his resigning from the position of Honorary Secretary after 18 years' service in that capacity. Dr. Spence was of a retiring disposition, but the members knew that the success of the Branch was the result of his untiring services. They parted reluctantly from him in the knowledge that his advice and long experience would still be available through his continued service on the committee.

Dr. Spence, in reply, referred to his membership of the Branch since 1921, when stalwarts like Meredith, Young, Naylor, Barlow and Joseph had made the North-Western the foremost Branch of the Society and to the subsequent development of a new generation whose present members had enhanced the position of the Branch in the councils of the Society.

He expressed the pleasure he had derived from carrying out the functions of the secretaryship during a period of 18 years and said that he was laying down the reins with regret and only because the passing of time made it inevitable. He thanked the President and the members of the Branch for their kind felicitations and for the handsome gift with which they had thought fit to present him, a gift which he intended to put to practical use when in the future he would have more time to devote to archaeological pursuits.

The Presidential Address entitled "Medical Administration" (which appeared in January *Public Health*) was then delivered. Dr. Hall conveying the thanks of the meeting to the President for his happy choice of subject and for the masterly and challenging way he had tackled it.

A meeting of the Branch was held at the Town Hall, Manchester, on Friday, December 9th, 1949, when 28 members were present.

It was resolved to nominate Drs. Hall and Semple to membership of the professional and scientific sub-committee of the Liverpool Regional Hospital Board Cancer Co-ordinating Committee.

It was agreed that a dinner be held in Manchester next March.

The President, in inviting Professor A. Topping to speak, referred to the pleasure with which the members had heard of the latter's promotion to the position of Dean of the London School of Tropical Medicine and the regret felt that this new appointment would terminate his direct connection with the North-Western Branch of which he was an ordinary member. Professor Topping thanked the members for their kind thoughts expressed through the voice of the President and then gave a valedictory address on experiences in a recent health survey, a brilliant travelogue packed with data showing penetrating insight into the fundamental problems existing and of such characteristic wit and hilarity that the recording secretary failed lamentably in his duty and no record of the address is extant.

Dr. Metcalfe Brown, on behalf of the Branch, thanked the speaker for a brilliant and devastating dissertation and wished him well in his new appointment.

#### SCOTTISH BRANCH

*President:* Dr. E. Neil Reid (M.O.H., Stirling C.C.).

*Hon. Secretary:* Dr. John Riddell (M.O.H., Midlothian and Peebles C.C.).

A meeting of the Branch was held at Westerlea School for Spastics, Ellersly Road, Edinburgh, 12, on Saturday, November 19th, 1949, at 10.15 a.m., when 24 members were present.

The Chairman introduced Mr. G. A. Pollock, F.R.C.S.E., M.S. ORTH. (MIND.), F.A.C.S., D.P.H., Orthopaedic Surgeon to the School, and Mr. Pollock gave a most enlightening talk on the origin, types, and treatment of the cerebral palsies. He pointed out that in the past too much emphasis had been laid on the associated mental deterioration. In fact, in some cases this was almost entirely absent. He stressed the need for continuous and lasting treatment over a period of years, and answered various questions, including the possible association of cerebral palsies with the Rh factor.

He was followed by Dr. J. A. L. Naughton, M.C., who spoke briefly on the psychological aspect pointing out that if disappointments were to be avoided in the treatment of cases, it was necessary to make an assessment of intelligence in all cases as a preliminary step. This was also necessary because of the dearth of places for children requiring treatment. He also answered a number of questions and thereafter the members were shown over the School, being given demonstrations by the staff of the children taking their exercises and of the various types of apparatus and toys which were used.

It was reported that Doctors Wattie and Fyfe had given evidence to the Advisory Council on the Welfare of Handicapped Persons

and that their evidence had been found to be most instructive and helpful.

The Secretary reported that he had communicated with the Secretary of the Philip Committee, drawing his attention to our disagreement with the terms of their Report.

The Secretary also reported that a Memorandum had been submitted to the Committee of Enquiry into the *Export and Slaughter of Horses*, suggesting:—

I. (a) That all dealers' premises should be registered with the local authorities.

(b) That the local authority should lay down the number of horses that can be accommodated.

(c) That the local authority's officers—that is, the Medical Officer of Health, the Sanitary Inspector and the Veterinary Inspector—should have free access to the premises at all times.

(d) That stabling should be available for all animals throughout their period in the premises.

II. (a) That the slaughtering of horses should be carried out in public abattoirs made suitable for the purpose.

(b) That the local authority be made responsible for supervising the care of the animals prior to slaughter.

(c) That every animal be inspected, preferably both ante- and post-mortem, the latter being obligatory in accordance with the system of inspection prescribed in detail.

(d) That the owners of the animals pay the local authority for services rendered.

The difficulty of following horse flesh from the place of slaughter to the point of consumption is realised, and it is recognised that any obligation on catering establishments to indicate that horse flesh is used in their premises might prove difficult, but it is suggested that a form of record should be kept which would make it clear to the officials concerned where horse flesh is used for human consumption.

*Report of Branch Council Meetings of July 2nd and September 24th, 1949.*

The Secretary reported the setting up of three Standing Committees:—(1) Child Health, (2) Environmental, and (3) General Purposes, with membership as follows:—

*Child Health:* Drs. J. A. Cuthbert, N. I. Wattie, C. A. Douglas, J. R. Adam, M. E. Mitchell, W. G. Clark, G. M. Fyfe, A. Fulton.

*Environmental:* Drs. G. M. Fyfe, W. G. Clark, J. A. C. Guy, R. L. Leask, I. C. Monro, J. R. Adam, W. A. Horne.

*General Purposes:* Drs. A. G. Reekie, G. V. T. McMichael, S. I. Laidlaw, S. K. Drainer, A. Allan, J. Kelman.

The President and Secretary being *ex-officio* members of each Committee, and the Secretaries of each Committee being as shown above (italics).

He also reported that the Council had formulated reports as follows:—

1. *Infectious Disease Exclusion Periods for School Children.*

This had been circulated to the Branch and to all Medical Officers of Health in Scotland.

2. *Hygiene of Catering Establishments—for the Catering Trade Working Party.*

The Secretary was instructed to circulate copies of this to the next Branch Meeting.

3. *Milk (Special Designations) Order (Scotland) 1936-44—for the Department of Health.*

The recommendations here were that the designation "Heat Treated" should be discontinued; that there should be annual re-registration of milk producers and retailers, and that sealing and locking of milk cans should be continued as a legal requirement.

4. *Admission to Hospital of Maternity Cases*

This was a report for the parent Society and recommended that case selection, especially on social grounds, should rest with the local health authority; also that it should be at the discretion of the Medical Officer of Health to decide whether or not a single report from either a midwife or a health visitor would be sufficient as a basis for assessment.

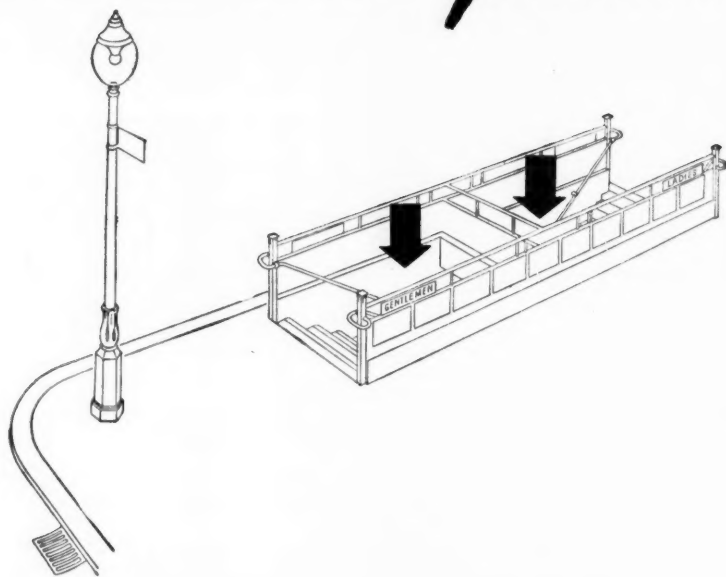
5. *Memorandum on Physically Handicapped Children—for the Advisory Council on Education in Scotland.*

This has been circulated to the Branch. Dr. Horne drew attention to the fact that there was no proper definition of "partially sighted," and it was agreed that the members to give evidence later should pay particular attention to this.

It was also reported that the Council had discussed the question of B.C.G. Vaccination and that all Medical Officers of Health in Scotland had been circulated advising them to ensure that in formulating their schemes it should be made perfectly clear that this was a responsibility of the local health authority and not of the Regional Hospital Board.

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**New Members**

The Secretary reported that the following had joined the Branch since the last Meeting:—

- Dr. Isobel C. Brown, Assist. Medical Officer of Health, Kirkcudbright.  
 Dr. Margt. D. McNair, Assist. Medical Officer of Health, Perth City.  
 Dr. D. I. Walker, Medical Officer of Health, Banff.  
 Dr. H. D. Wallace, Div. Medical Officer, Glasgow.  
 Dr. E. H. W. Duncan, Assist. Medical Officer of Health, Greenock.  
 Dr. J. R. W. Hay, Medical Officer of Health, Kirkcaldy.  
 Dr. Alice M. Insh, Assist. Medical Officer of Health, Lanarkshire.

**Correspondence**

(1) *Association of School Medical and Dental Officers of Scotland*  
 The Secretary read a letter assuring the Society that in any negotiations regarding the salaries paid to School Medical Officers it could count on the full help and support of the above Association.

(2) *Sir Andrew Davidson—Status of Sanitary Inspectors*

This was a letter drawing attention to the difficulties of determining proper relationship between Medical Officers of Health and Sanitary Inspectors, and asking that Representatives of the Society should discuss the matter informally with the Department. The matter was remitted to the Council for consideration.

(3) *Scottish Health Services Council*

A letter was read from the Secretary of the above, drawing attention to the fact that various Representatives on the Council and the Standing Advisory Committees were due to retire at December 31st, and inviting any nominations from the Society. As none of our members were affected it was decided not to make any nominations.

(4) *Milk (Special Designations) (Scotland) Amendment Order, 1949*

A letter was read from the Department of Health, stating that this Order had been issued hurriedly without time for prior discussion with interested bodies, but that it was intended to proceed with a consolidation of the various Milk (Special Designations) (Scotland) Orders issued since 1936, and that consultations in that connection could cover any points arising on the present Order.

**WELSH BRANCH**

*President:* Dr. Kathleen Davies (Div. M.O., Mid-Glamorgan).

*Hon. Secretary:* Dr. Mary Lennox (M.O.H., Barry M.B.).

A meeting of the Branch was held at the Institute of Preventive Medicine, Cardiff, on Friday, December 9th, 1949. The President, 16 members and guests were present.

The President welcomed Mr. J. M. S. Dixon as the successful candidate for the Prize presented to the best student in the Hygiene examination of the M.B., B.Ch. (Wales).

The prize consisted of two books, "Wanderings in Wales," W. A. Poucher, and "Early Recognition of Disease," Ogilvie.

The President then introduced Dr. G. A. Hodgson, M.B.E., M.D., Dermatologist, Cardiff, who spoke on "Some Common Diseases of the Skin in Infancy and Childhood."

Dr. Hodgson grouped skin diseases into infections and specific and non-specific skin reactions.

He divided naevi into vascular and non-vascular types and gave details of treatment.

The napkin dermatitis could be classified as—(a) ammonia type, (b) intertrigo, (c) contact dermatitis, (d) thrush.

Scabies was also dealt with and the reasons for the continued itching after treatment were given.

Infantile eczemas were divided into four main groups: exudative, allergic, ichthyotic and infective, and the treatment given for each.

He also dealt briefly with psoriasis, pyogenic infections of the skin and urticaria.

At the close of the address the President thanked the speaker, and the subject was opened for discussion. Several questions put by various members were answered.

**WEST OF ENGLAND BRANCH**

*President* (1948-49): Dr. B. A. Astley-Weston (M.O.H., Bath C.B.). (1949-50): Dr. R. L. Midgley (M.S., Hawkmoor Sanatorium, Devon).

*Hon. Secretary:* Dr. R. H. G. H. Denham (M.O.H., Bathavon, Keynsham and Frome; A.C.M.O.H., Somerset).

A meeting of the West of England Branch of the Society was held at the Palace Hotel, Torquay, on Saturday, July 2nd, 1949. The President, ten members and six guests, attended.

The meeting was preceded by a luncheon and a continuation by Dr. Midgley of the talk on his experiences in America which he gave at the January meeting at Taunton. The speaker confined

himself chiefly to a description of Los Angeles and to his impressions of the film industry at Hollywood. Those present found this vastly entertaining and Dr. Simpson paid tribute to Dr. Midgley's eloquence and feat of memory when he thanked him on behalf of the company for his extremely interesting address.

A short business meeting followed when the following officers were elected for the 1949-50 session:—

*President:* Dr. R. L. Midgley.

*Vice-President:* Dr. J. M. Cormack.

*Secretary and Council Representative:* Dr. R. H. G. H. Denham.

*Hon. Treasurer:* Dr. B. A. Astley-Weston.

*Representatives on T.B. Group:* Dr. R. L. Midgley, Dr. J. S. Harper.

Dr. Midgley made reference to Dr. Blackett's retirement from the office of Treasurer which he has held for the past 28 years and asked that the thanks of the Branch members to Dr. Blackett for his devoted service over such a long period be recorded in the minutes. This was carried with acclamation.

**DENTAL OFFICERS' GROUP**

*President:* John Young, L.D.S. (Chief D.O., Glamorgan C.C.).

*Hon. Sec.:* J. V. Bingay, M.B.E., L.D.S. (Area D.O., Middlesex C.C.).

**General Meeting, October 22nd, 1949**

A general meeting of the Group was held in the Hastings Hall on Saturday, October 22nd, 1949, at 2 p.m. The President was in the chair and rather more than 40 members and visitors were present. After the minutes of the previous meeting had been confirmed, the President called upon Mr. K. C. B. Webster, Chairman of the Group Council, to outline the present position in regard to Salary negotiations. Mr. Webster explained how the Local Authorities' Associations had met at the end of July, and had agreed to enter the National Health Service Whitley machinery, provided that Dental Officers' salaries were negotiated by an autonomous Committee not requiring ratification by, but subject only to report to, the Dental Functional Council. After consideration the ban on advertisements in the professional journals had been lifted. At the end of September an informal meeting between representatives of the dental organisation was held at Hill Street. Representatives from the Ministry of Health were present and many questions were asked and answered. As a result of this meeting the Council of the British Dental Association had agreed to recommend the acceptance of Whitleyism to the Representative Board at the end of October. Information had also been received that the attitude of the Public Dental Service Association remained in doubt. There had been some criticism of the lifting of the ban on advertisements, but it had served its purpose in bringing the Local Authorities into the negotiating machinery, and the British Medical Association had taken similar action. It was also customary when negotiations were in progress to lift bans of this kind.

The President then called on Mr. J. F. Pilbeam, F.D.S., Chief Dental Officer, Middlesex County Council, to read his paper on "Dental Auxiliaries—including the New Zealand Scheme." An excellent discussion followed in which many viewpoints were put forward. A vote of thanks to Mr. Pilbeam for his paper was proposed by Mr. Gordon Taylor, and seconded by Mr. Peacock, and carried by acclamation. (Mr. Pilbeam's paper, together with the discussion, are published in other pages of this issue.)

**Group Council Meeting**

A meeting of the Group Council was held at Tavistock House on Saturday, October 22nd, 1949, at 9.45 a.m. Mr. K. C. B. Webster, Chairman of the Group Council, presided, and also present were: Messrs. K. Batten, J. V. Bingay, Mrs. E. E. Clausen, Messrs. M. Cohn, G. M. Davie, H. B. Fleming, J. Fletcher, P. G. Oliver, J. F. Pilbeam, J. F. A. Smyth, Miss A. S. Stewart, and John Young. Mr. Smyth also acted in the capacity of Observer from the Public Dental Officers' Group of the British Dental Association.

Minutes of the previous meeting were read and approved. Arising from the minutes, Mr. Oliver asked whether Local Authorities were taking part in the experiment in the use of Dental Hygienists. The Chairman, in reply, stated that approximately a dozen who had formerly been employed in the R.A.F. had been given a Refresher Course at the Eastman Dental Clinic and had been allocated to Local Authorities. In regard to inter-Group observers, Mr. Smyth reported that the suggestion that on occasions deputy observers might be sent did not meet with a favourable response from the Public Dental Officers' Group of the British Dental Association.

**Reports of Sub-Groups.**

**London and Home Counties.**—Mr. H. B. Fleming reported that a well-attended meeting had been held on September 23rd. Films on Jacket Crowns and Oral Surgery had been shown by the courtesy of Messrs. S. S. White & Co.

**Welsh Sub-Group.**—Owing to the bad staffing position in the area it was still found impossible to hold meetings. For example, Glamorganshire had lost 12 Dental Officers, six still remained and two resignations were pending.

**Report of Hon. Membership Secretary**

Mr. M. Cohn reported that the Membership was now checked as being 197. Mr. Webster commented on the present need for a strong membership of the Group. The Hon. Editor of Transactions was instructed to revise and bring up to date the Group brochure.

**Report of Joint Committee**

Mr. Bingay reported that there had been a great deal of activity since July 26th, when Local Authorities' Associations had met and agreed to come into the National Health Service Whitley Machinery with certain slight reservations. It was now a question of hammering out the differences between the Dental Associations on the subject. The Council of the British Dental Association had agreed to participate and the matter was for confirmation by the Representative Board of the Association at their meeting the following week. The Incorporated Dental Society had already reached agreement, but the attitude of the Public Dental Service Association was still doubtful. There had been a conference attended by representatives of the Dental Associations and the Joint Committee, together with officials from the Ministry of Health on September 29th. Members of the Group had been able to formulate their questions to these officials in such a way that the replies elicited had led the representatives of the other Associations to view Whitley Machinery in a more favourable light.

**Report of Representatives on Council of Society**

Mr. A. G. Taylor reported that in the matter of representation on the Dental Functional Council, the Council of the Society were solidly behind the Group. It had been a revelation of the high esteem in which Public Dental Officers and the Group were held by the Council. (See page 11 of the October issue of *Public Health* Report of Council meeting, Minute 69 (c).)

**Report of Observer on Public Dental Officers' Group Committee of the British Dental Association.**

Mr. Bingay stated that he had reported the action the Group had been authorised to take in regard to representation on the staff side of the Dental Officers' Whitley Council by the Council of the Society should the other dental organisation decide to hold aloof. He paid a tribute to their sister Group in the British Dental Association.

**Elections of Committees and Representatives of the Group Council on other Bodies**

(a) **Joint Committee:** Messrs. Bingay, Donaldson, Fletcher, and Webster.

(b) **Refresher Course Sub-Committee:** Mr. Bingay, Miss Stewart, Mr. Cohn and Mr. Webster.

(c) **Representatives on Council of the Society:** Messrs. Taylor, and Bingay.

(d) **Inter-Group Committee:** Messrs. Bingay, Davie and Taylor.

(e) **Representative on Tuberculosis Group Committee:** Mr. P. G. Oliver.

(f) **Representative on Child Study Society:** Mrs. Clausen.

(g) **Observer on Public Dental Officers' Group Committee of the British Dental Association:** Mr. Bingay.

(h) **Committee on Prevention of Dental Diseases:** Messrs. Donaldson, Taylor, and Ritchie Young.

**Financial Statement**

The Hon. Treasurer reported that during the past year owing to the Group's abnormal activities in the dento-political sphere it had been necessary to dip rather deeply into the Group's reserves. Drastic cuts in expenditure had become necessary. An *ad hoc* Committee, consisting of Messrs. Batten, Fletcher and Smyth, was set up to consider economies in Group expenditure.

**MATERNITY AND CHILD WELFARE GROUP**

**President:** Dr. J. D. Kershaw (M.O.H., Colchester M.B.).

**Hon. Secretary:** Dr. Kathleen M. Hart (Sen. Asst. M.O., Ealing and Acton Div., Middlesex).

**Hon. Asst. Secretary:** Dr. Mabel Dodds (Sen. A.M.O., Middlesex).

A general meeting was held in the Hastings Hall, B.M.A. House, on Saturday, November 5th, 1949. The President was in the chair, and 24 members were present.

**Speech Defects**

The President introduced Dr. Mary Sheridan of the Children's Branch of the Home Office, who spoke to an appreciative audience on speech defects in children. The talk was illustrated by lantern slides, and was vivid and entertaining as well as instructive. We heard how Dr. Sheridan was first led to investigate deafness after meeting with children who were thought to be mentally retarded when they were, in fact, deaf. In order to do this, Dr. Sheridan, herself, took up the study of elocution and phonetics, and she told several amusing stories of her experiences during these studies.

In investigating speech defects connected with deafness it has been found that sounds fall into groups as far as ease or difficulty in discrimination between them is concerned—from the comparatively easy to hear vowels to the difficult "s" "f" "th" sounds.

For diagnosis the old-fashioned bowl banging and hand clapping can now be replaced by audiometers, of which there are three forms in use in this country—the gramophone, the speech and the pure tone. Response to tests is charted, and we were shown charts of the three principal types of deafness—the low tone, the high tone, and that of almost even loss of hearing over the entire speech range.

**NORTH-WESTERN M. & C.W. AND S.H.S. GROUPS**

**President:** Dr. J. E. Spence (M.O.H., Eccles M.B.).

**Hon. Secretary:** Dr. E. M. Jenkins (Chief A.S.M.O., Manchester C.B.).

A meeting of the Groups was held at the Children's Hospital at Pendlebury, on Friday, December 2nd, at 5 p.m., 18 members being present.

Dr. Ward, the senior physician, assisted by Dr. Sweetman and Dr. Sheldon, gave a clinical demonstration of eight most interesting cases of children with rare diseases. Two cases of extensive pulmonary tuberculosis—one in a baby of 18 months—were shown. These had no fever and very few symptoms, and had been treated by streptomycin. The baby had also bilateral tuberculosis of the metacarpals in both hands.

One case of each of the following conditions was shown: Hirschsprung's disease, congenital obstruction of the bowel duct, and reticulosis, and also two cases of acute rheumatic fever in children, which had been sent in as surgical emergencies. A brief discussion took place, after the demonstration of each case, as to the differential diagnosis.

The President expressed the sincere thanks of the Group to Dr. Ward, and other members of the staff concerned, for their most interesting demonstration.

**TUBERCULOSIS GROUP**

**President:** Dr. T. W. Davies (Chest Physician, Swansea).

**Hon. Secretary:** Dr. R. L. Midgley (M.S., Hawkmoor Sanatorium, Devon).

A meeting of the Tuberculosis Group Committee was held at the rooms of the Society at 10 a.m. on Friday, November 18th, 1949.

The President occupied the chair and there were present Drs. C. K. Cullen, G. B. Charnock, R. M. Orpwood, J. G. S. McQueen, G. Lissant Cox, G. M. Townsend, J. E. Geddes, H. Villiers, P. W. Edwards, H. Ramsay and R. L. Midgley.

Apologies for absence were received from Drs. B. Clarke, J. W. Wilson and S. H. Graham.

**Matters arising.**—There was nothing so far to report on the ice cream experiments.

The Council Representative presented his report and stated:—(1) The position regarding notification of admission and discharge of tuberculosis patients was still under consideration by the Ministry of Health; (2) the Hon. Treasurer had stated he was considering advising Council to discontinue paying the £5 grant to Groups. This was viewed with alarm in view of the precarious state of the Group's finances, and it was decided that a letter of protest should be written and a copy sent to the M. & C.W. Group, who had sent us a letter on this matter.

The Joint Tuberculosis Council representative presented his report. Dr. Edwards gave an account of the first meeting and subsequent activities of the Tuberculosis and Chest Diseases Group of the B.M.A. It was noted with satisfaction that Drs. P. W. Edwards, C. K. Cullen, H. Ramsay, J. E. Geddes and T. W. Davies were members of the Committee, and that the Group already had some 500 members.

A discussion ensued on the question of tuberculosis as a scheduled industrial disease for nurses and other health workers specially exposed to infection. The next meeting will take place at 10 a.m. on Friday, February 17th, 1950.



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## TUBERCULOSIS EDUCATIONAL INSTITUTE REFRESHER COURSES

Refresher courses are being arranged at Davos, Switzerland, and in London during the early part of 1950, and bookings for these can now be accepted.

The DAVOS Course for doctors only is being organised in conjunction with the Davos Medical Society, and will include clinical demonstrations. Subject to a sufficient number of applications being received the Course will be held from the 25th March to the 2nd April 1950. Expenses are estimated as follows:— Fare approximately £2 (2nd class return), Accommodation approximately 2½ francs per day, Lecture Fee 2½ francs, Registration Fee £1 1s. (payable in advance to the Secretary, Tuberculosis Educational Institute).

The LONDON Courses on TUBERCULOSIS IN CHILDREN AND THE USE OF B.C.G. will be of interest to Doctors (especially those attached to the School Medical Service), School Nurses, Health Visitors, Administrators and Social workers. They are to be held in the Medical School at St. Thomas's Hospital, S.E.1. on the 18th 19th and 20th April, 1950. Visits to a London Hospital and Chest Clinic will be arranged on the 21st April. The fee for doctors is £4 4s., and that for School Nurses and others £1 1s.

Approval of the London Courses has been granted by the Minister of Education, who will take into account for purposes of grant reasonable expenditure by Local Education Authorities in respect of attendance of their School Medical Officers and School Nurses at the Courses.

Applications for further information and enrolment should be addressed to the Secretary.

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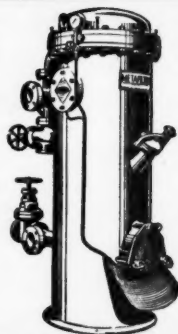


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